(b) The rights of a beneficiary under paragraph (a) of this section to appeal the carrier's initial determination are granted also to—

(1) A physician or supplier that furnishes services to a beneficiary and that accepts an assignment from the beneficiary, or

(2) A physician who meets the conditions of section 1842(l)(1)(A) of the Act pertaining to refund requirements for nonparticipating physicians who have not taken assignment on the claim(s) at issue.

(c) Procedures governing the determinations by SSA as to whether an individual has met basic Part B entitlement requirements are covered in subpart G of this part and 20 CFR part 404, subpart J. Subparts J and R of 20 CFR part 404 are also applicable to ALJ, DAB, and judicial review conducted under subpart H, except to the extent that specific provisions are contained in this subpart.

[62 FR 25853, May 12, 1997]

§ 405.802 Definitions.

As used in subpart H of this part, the term—

After receipt of the notice means 5 days after the date on the notice, unless it is shown that the notice was received earlier or later.

Appellant designates the beneficiary, assignee or other person or entity that has filed an appeal concerning a particular determination of benefits under Medicare part B. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Assignee means a physician or supplier who furnishes services to a beneficiary under Medicare part B and who has accepted a valid assignment executed by the beneficiary.

Assignment means the transfer by the assignor of his or her claim for payment to the assignee in return for the latter's promise not to charge more for his or her services than the carrier finds to be the reasonable charge or other approved amount.

Assignor means a beneficiary under Medicare part B whose physician or supplier has taken assignment of a claim.

Carrier means an organization which has entered into a contract with the Secretary pursuant to section 1842 of the Act and which is authorized to make determinations with respect to part B of title XVIII of the Act. For purposes of this subpart, the term carrier also refers to an intermediary that has entered into a contract with the Secretary under section 1816 of the Act and is authorized to make determinations with respect to part B provider services, as specified in § 421.5(c) of this chapter.

Common issues of law and fact, with respect to the aggregation of claims by two or more appellants to meet the minimum amount in controversy needed for an ALJ hearing, occurs when the claims sought to be aggregated are denied or reduced for similar reasons and arise from a similar fact pattern material to the reason the claims are denied.

Delivery of similar or related services, with respect to the aggregation of claims by two or more physician/supplier appellants to meet the minimum amount in controversy needed for an ALJ hearing, means like or coordinated services or items provided to the same beneficiary by the appellants.

Representative means an individual meeting the conditions described in §§ 405.870 through 405.871.

With reasonable promptness means within a period of 60 consecutive days after the receipt by the carrier of a request for payment.

[59 FR 12182, Mar. 16, 1994, as amended at 62 FR 25853, May 12, 1997]

§ 405.803 Initial determination.

(a) Carriers make initial determinations regarding claims for benefits under Medicare Part B.

(b) An initial determination for purposes of this subpart includes determinations such as the following:

(1) Whether services furnished are covered.

(2) Whether the deductible has been met.

(3) Whether the receipted bill or other evidence of payment is acceptable.

(4) Whether the charges for services furnished are reasonable.

(5) If the services furnished to a beneficiary by a physician or a supplier pursuant to an assignment under §424.55 of this chapter are not covered because they are determined to be not reasonable and necessary under §411.15(k) of this chapter, whether the beneficiary, physician or supplier, or a physician who meets the requirements of §411.408, knew or could reasonably have been expected to know at the time the services were furnished that the services were not covered.

(c) The following are not initial determinations for purposes of this subpart:

(1) Any issue or factor for which SSA or CMS has sole responsibility, for example, whether an independent laboratory meets the conditions for coverage of services; whether a Medicare overpayment claim should be compromised, or collection action terminated or suspended.

(2) Any issue or factor which relates to hospital insurance benefits under Medicare Part A.

[62 FR 25853, May 12, 1997]

§405.804 Notice of initial determination.

After a carrier has made an initial determination on a request for payment written notice of this determination shall be mailed to each party to the determination at his last known address. The notice of the determination shall inform each party to the determination of his right to have such determination reviewed.

§405.805 Parties to the initial determination.

The parties to the initial determination (see §405.803) may be any party described in §405.802.

[64 FR 52670, Sept. 30, 1999]

§405.806 Effect of Initial Determination.

The initial determination is binding upon all parties to the claim for benefits unless the determination is—

(a) Reviewed in accordance with §§405.810 through 405.812; or

(b) Revised as a result of a reopening in accordance with §405.841.

[62 FR 25853, May 12, 1997]

§405.807 Request for review of initial determination.

(a) *General.* A party to an initial determination by a carrier, that is dissatisfied with the initial determination and wants to appeal the matter, may request that the carrier review the determination. The request for review by the party to an initial determination must clearly indicate that he or she is dissatisfied with the initial determination and wants to appeal the matter. The request for review does not constitute a waiver of the party's right to a hearing (under §405.815) after the review.

(b) *Place and method of filing a request.* A request by a party for a carrier to review the initial determination may be made in one of the following ways:

(1) In writing and filed at an office of the carrier, SSA, or CMS.

(2) By telephone to the telephone number designated by the carrier as the appropriate number for the receipt of requests for review.

(c) *Time of filing request.* (1) The carrier must provide a period of 6 months after the date of the notice of the initial determination within which the party to the initial determination may request a review.

(2) The carrier may, upon request by the party, extend the period for requesting the review of the initial determination.

[64 FR 52670, Sept. 30, 1999]

§405.808 Parties to the review.

The parties to the review (as provided for in §405.807(a)) shall be the persons who were parties to the carrier's initial determination as described in §405.805, and any other party whose rights with respect to the particular claim being reviewed may be affected by such review.

[39 FR 12097, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977]

§405.809 Opportunity to submit evidence.

The parties to the review (as provided for in §405.807(a)) shall have a