(3) If a revocation of a supplier's billing privilege is reversed upon appeal, the supplier's billing privileges are reinstated back to the date that the revocation became effective.

(4) If the denial of a supplier's billing privileges is reversed upon appeal and becomes binding, then the appeal decision establishes the date that the supplier's billing privileges become effective.

(e) *Reinstatement of provider or supplier billing privileges following corrective action.* If a provider or supplier completes a corrective action plan and provides sufficient evidence to the CMS contractor that it has complied fully with the Medicare requirements, the CMS contractor may reinstate the provider's or supplier's billing privileges. The CMS contractor may pay for services furnished on or after the effective date of the reinstatement. The effective date is based on the date the provider or supplier is in compliance with all Medicare requirements. A CMS contractor's refusal to reinstate a supplier's billing privileges based on a corrective action plan is not an initial determination under part 498 of this chapter.

(f) *Effective date for DMEPOS supplier's billing privileges.* If a CMS contractor, contractor hearing officer, or ALJ determines that a DMEPOS supplier's denied enrollment application meets the standards in §424.57 of this chapter and any other requirements that may apply, the determination establishes the effective date of the billing privileges as not earlier than the date the carrier made the determination to deny the DMEPOS supplier's enrollment application. Claims are rejected for services furnished before that effective date.

(g) *Submission of claims.* A provider or supplier succeeding in having its enrollment application denial or billing privileges revocation reversed in a binding decision, or in having its billing privileges reinstated, may submit claims to the CMS contractor for services furnished during periods of Medicare qualification, subject to the limitations in §424.44 of this chapter, regarding the timely filing of claims. If the claims previously were filed timely but were rejected, they are considered filed timely upon resubmission. Previously denied claims for items or services rendered during a period of denial or revocation may be resubmitted to CMS within 1 year after the date of reinstatement or reversal.

(h) *Deadline for processing provider enrollment initial determinations.* Contractors approve or deny complete provider or supplier enrollment applications to approval or denial within the following timeframes:

(1) *Initial enrollments.* Contractors process new enrollment applications within 180 days of receipt.

(2) *Revalidation of existing enrollments.* Contractors process revalidations within 180 days of receipt.

(3) *Change-of-information and reassignment of payment request.* Contractors process change-of-information and reassignment of payment requests within 90 days of receipt.

[73 FR 36460, June 27, 2008, as amended at 73 FR 69932, Nov. 19, 2008]

§405.877 Appeal of a categorization of a device.

(a) CMS's acceptance of the FDA categorization of a device as an experimental/investigational (Category A) device under §405.203 is a national coverage decision under section 1862(a)(1) of the Act.

(b) CMS's acceptance of the FDA categorization of a device as an experimental/investigational (Category A) device under §405.203 is an aspect of an initial determination that, under section 1862 of the Act, payment may not be made.

(c) In accordance with section 1869(b)(3)(A) of the Act, CMS's acceptance of the FDA categorization of a device as an experimental/investigational (Category A) device under §405.203 may not be reviewed by an administrative law judge.

[60 FR 48424, Sept. 19, 1995]

Subpart I—Determinations, Redeterminations, Reconsiderations, and Appeals Under Original Medicare (Part A and Part B)

SOURCE: 70 FR 11472, Mar. 8, 2005, unless otherwise noted.