Self Help Packet for Medicare "Observation Status"

INTRODUCTION

Dear Medicare Patient:

The Center for Medicare Advocacy has produced this packet to help you understand Medicare coverage and to file an appeal if appropriate.

Medicare is the national health insurance program to which many disabled individuals and most older people are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial; we urge you to do so.

If you have any questions, contact the Center for Medicare Advocacy at (860) 456-7790.

HOW TO USE THIS PACKET

We've organized this packet so that it provides you with the information needed to understand observation status and to attempt to rectify the problems created by it through the Medicare administrative appeal process.

1. Read the document entitled, **Observation Status Self-Help** included in this packet.
2. If you decide to file an appeal, follow each of the steps in the following Self-Help document.
3. Review the enclosed regulations to assist you with the appeal.
4. If you have questions, contact the Center for Medicare Advocacy at (860) 456-7790.

OBSERVATION STATUS SELF-HELP

Typical Scenario

You are a Medicare beneficiary who is currently or has recently been hospitalized for three or more days. At the hospital you signed admission paperwork, slept in a hospital bed, underwent many tests, and saw various physician specialists. At some point during the hospitalization or while you were being discharged you were told that the discharging physician ordered follow up care in a skilled nursing facility (nursing home). You were also told that Medicare will not pay for this care because you were admitted to the hospital on observation status rather than as an inpatient.

Introduction

Observation status is not new. However, its use by hospitals to avoid lost revenue, scrutiny and accusations of Medicare fraud is growing. This seriously affects Medicare beneficiaries' access to care and finances. Attempts have been made to remedy the problem legislatively. For instance, bills have been introduced in Congress to eliminate the problem. In addition, the Center for Medicare Advocacy (Center) filed a national class action lawsuit, *Bagnall v. Sebelius,* challenging the practice in 2011. While we wait for action on the legislation and the lawsuit, individual beneficiaries continue to be negatively affected by observation status.

This packet includes information about observation status and steps you might take to resolve the problems created by an observation status hospital designation. For more information about observation status, visit the Center's webpage at: www.medicareadvocacy.org. This process is complicated and confusing. Should you have questions, call the Center for Medicare Advocacy at (860) 456-7790.

1.Inpatient Admission

Medicare Part A pays for hospital inpatient care. In traditional Medicare, there is an initial deductible and, if you are hospitalized for more than 60 days, there are daily copayments. While you are hospitalized as an inpatient, Medicare Part B pays for the care provided by physicians, usually covering 80% of the Medicare approved cost. Medigap policies or other supplemental insurance usually pay for the hospital deductible, copayments, and Part B cost sharing.

Medicare Part A will only pay for hospital care if a physician orders inpatient care. To assist physicians with determining whether a patient/beneficiary should be admitted to the hospital as an inpatient, the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, published the following guidance in its policy manuals:

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of each setting.[1]

If a hospital participates in the Medicare program, all of its physician inpatient admission orders must be reviewed by the hospital's utilization review committee (URC). The URC has the power to overturn any admitting physician's admission order and to reassign patients to observation status.

2.Recovery Audit Contractors (RACs)

Recovery Audit Contractors (RACs) are hired by CMS to review, audit, and identify what they believe to be improper Medicare payments. If the RAC retroactively overturns a hospital's decision to admit a patient as an inpatient, the hospital will lose a lot of money. Because of this threat, hospital physicians and URCs are increasingly admitting Medicare beneficiaries on *observation status* rather than as inpatients. When hospitals do this, they bill Medicare Part B for hospital outpatient care rather than Medicare Part A for inpatient care.

3.Observation Status

Observation status is defined by CMS in its policy manuals as:

…a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment

or monitoring in order to make a decision concerning their admission or discharge. Observation services

are covered only when provided by the order of a physician or other individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.[2]

When a Medicare patient is placed on observation status, despite the fact that the patient is physically in the hospital, the care for billing purposes is considered outpatient care. The hospital bills Medicare Part B for each service provided (such as lab tests, intravenous medications, MRIs, EKGs).

If you are put on observation status, you will be responsible for the hospital Part B copayments and you could be responsible for the cost of any self-administered (prescription or over-the-counter) medications you receive while hospitalized. On the other hand, you will not be responsible for the inpatient deductible.

4.The Heart of the Problem

When Medicare beneficiaries are put on observation status, Medicare Part B generally covers most of their care. The Part B cost sharing is usually paid for by a Medigap policy or some other form of supplemental health insurance. However, if the beneficiary has opted out of Medicare Part B entirely, the hospitalization under observation could be very expensive because *nothing* will be covered by Medicare.

As a general rule, most beneficiaries are not burdened with the financial cost of the hospital stay, but by the care they receive after the hospitalization in a nursing home.

Medicare Part A will pay for care in a skilled nursing facility (nursing home) only if the care follows a Medicare Part A covered three day *inpatient* stay in a hospital. For purposes of measuring days, the Medicare program uses calendar days, not 24-hour periods. For example, if a person is admitted to the hospital at 11:50 p.m., Medicare will count that day as the first day of admission, even though the person was "admitted" for only ten minutes. The shorthand way of describing the three day qualifying hospital stay requirement is "three midnights."

Any "midnight" on observation status does not count towards the three day qualifying hospital stay. **Thus, if the patient requires care in a nursing home after a hospital stay on observation status, even if that stay was for three or more days, Medicare will not pay for it.** Of course nursing home care is *very expensive.*

What You Can Do

Step One: *Find Out Your Admission Status*

Understandably, patients think that if they are kept in the hospital and spend the night in a hospital room, they are inpatients. Now that hospitals are increasingly using observation status, however, you cannot make this assumption. **So when you are hospitalized, find out whether you have been admitted as an inpatient or on observation status**. Ask your treating physician. If your physician is unclear regarding your status, ask to speak to someone in the case management department.

Step Two: *Try to Get Your Status Changed*

If you find out that you are on observation status and are concerned about Part B cost sharing, the cost of self-administered medications, and/or Medicare payment for care in a skilled nursing facility after you leave the hospital; *try* to get the status changed while you are at the hospital. This will be difficult to do. Your best chance of success is having your community physician (regular doctor) talk to your treating physician at the hospital. Ask your community doctor to intervene on your behalf. He or she knows your medical history and speaks the same medical jargon as the hospital physician. Your community doctor might be able to convince the hospital physician that your status at the

hospital should be changed from observation to inpatient.

Step Three: *Prepare For Discharge*

In the event that you are not successful with changing your hospital observation status, but need follow up medical care, you have some decisions to make. If you can safely return home, ask your hospital or community physician to order home health care. So long as you are homebound (leaving home requires a taxing effort and occurs infrequently) and you require skilled care (skilled nursing or physical or speech therapy), Medicare should pay for this care. Have this care set up for you by the hospital before you leave as part of your safe discharge plan. You can find out more about home health care on the Center's website at www.medicareadvocacy.org.

Step Four: *Understand that Medicare Will Not Pay for Nursing Home Care After a Hospitalization on Observation Status*

If you cannot safely return home, and the discharge physician has ordered care for you in a skilled nursing facility (nursing home), check to see if the nursing home participates in the Medicare program. Unfortunately, since you were not admitted to the hospital as an inpatient, Medicare will not pay for this necessary care without a significant effort.

You might be able to appeal this denial of coverage for your nursing home care so long as you spent three midnights in the hospital (not in the emergency room). Unfortunately, this appeal process can take a year or longer to resolve and winning the case is difficult. Also, filing an appeal does not prevent the nursing home from requiring you to pay for your care pending the outcome of the appeal.

Step Five: *Start the Nursing Home Appeal*

If you decide to get care in a nursing home and it will be provided on a daily basis (five days a week of therapy or seven days a week of skilled nursing), let the nursing home know that you are going to appeal the denial of Medicare coverage. Medicare will only pay for a nursing home stay if it includes daily skilled care. Skilled care is care that is so *inherently complex* that it must be done by a skilled professional. The skilled nursing and/or therapy can be to improve or maintain your condition. Medicare will not pay for care in a nursing home when it is only custodial. Examples of custodial care include the administration of oral medications or assisting a patient with bathing or toileting. For more information about Medicare coverage of skilled nursing facility care, and how to appeal a denial visit our website at www.medicareadvoacy.org.

To start the appeal, ask the nursing home to submit a "demand bill" to Medicare for your entire stay. You can make this request after you leave the nursing home. However, note that nursing homes must bill Medicare within one year of the time the care began. So do not wait too long to make this request. In response to the demand bill, CMS will issue a denial of payment from which you can appeal.

Step Six: *Request a Redetermination for the Nursing Home Denial*

You will receive an MSN in the mail which will reflect the nursing home's bill to Medicare. The MSN will indicate that Medicare has denied payment for your care in the nursing home because you did not have a *three day qualifying hospital stay.* Read the last page of the MSN. It will tell you that you have 120 days to appeal the denial of coverage. Follow the instructions on how to and file an appeal. Circle the denial of payment for your nursing home care. Write that you are appealing because you did receive three days of hospital inpatient care. If you have a copy of your hospital discharge summary reflecting that you were hospitalized for three days, send a copy of it with your MSN requesting an appeal.

Step Seven: *Gather Hospital Records*

Write to the hospital and ask for a copy of your medical record. Ask that it send you the following documents: emergency room records; admission records; physician orders; consultation reports; lab reports; diagnostic imaging; medical records; nursing narratives; discharge summary; and social service documentation. The hospital may charge

you for copying and sending the documents. These charges are not allowed in some states, including Connecticut and Massachusetts. When you get the records, give a copy of them to your community physician. Ask your physician to review the records and to write a statement explaining that the care you received while hospitalized was inpatient hospital care.

Step Eight: *Gather Nursing Home Records*

Write to the nursing home and ask for a copy of your medical record. Ask for the following documents: MDS forms; physician orders; physician progress notes; medication records; therapy records (physical, occupational, and speech), nursing narrative notes; and physician certifications. As with the hospital medical records, the nursing home may charge you for copying and sending these documents. Also write to the nursing home physician and ask that he or she write a letter for you explaining that while you were a patient at the nursing home, you required and received a skilled nursing facility level of care.

Step Nine: *Request a Reconsideration for the Nursing Home Denial*

You should receive a "Redetermination" decision in the mail for your nursing home care. It will be "unfavorable." You will have 180 days to appeal. Follow the directions on the form for requesting a "Reconsideration." On the nursing home appeal request, write that you are appealing because you were hospitalized and received an inpatient level of care for three consecutive days prior to receiving care at the skilled nursing facility. If you have letters from physicians in support of your case, send copies with your request.

Step Ten: *Request an ALJ Hearing*

You should receive a "Reconsideration" decision in the mail for your nursing home care. Again this will be a denial. You will have 60 days to appeal. Follow the directions on the form for requesting an administrative law judge (ALJ) hearing. ALJ appeals are often successful.

Step Eleven: *Respond to the Notice of Hearing*

You will receive a written notice of hearing in the mail. Respond to the notice as directed. **Make sure that the notice states that a video teleconference is scheduled. If it does not, contact the ALJ and request that the hearing be rescheduled as a video teleconference**. Also ask the judge to send you a copy of the exhibit list and hearing file.

Step Twelve: *Prepare for the Hearing*

When you receive the hearing file, make sure that it includes all the medical records that you have obtained from the hospital and the skilled nursing facility. If it does not, send the missing records to the ALJ. Be sure and send a copy of the letters of support you received from your physicians. Contact the nursing home and ask if a therapist or nurse will testify at the hearing on your behalf.

Step Thirteen: *Argue your Case*

Attend the hearing. Make sure the judge has the additional records that you sent in. If you can, have someone from the nursing home testify that the care you received while there was skilled care and that it was performed on a daily basis. Explain to the judge that your care at the skilled nursing facility was not covered by Medicare because the hospital erroneously billed your inpatient hospital level of care to Medicare Part B rather than A. Ask the judge to find that your hospital care was an inpatient level of care and that you've met the three day qualifying hospital stay requirement for skilled nursing facility care. Then ask the judge to find that your skilled nursing facility care was medically reasonable and necessary and coverable by Medicare Part A.

Step Fourteen: *If You Lose the Appeal*

You will receive the administrative law judge's decision in the mail. If it is favorable, send a copy to the nursing home

and ask that it reimburse you if you previously paid for any care or ask that it stop any collection efforts started against you. If it is unfavorable, follow the directions on the hearing decision for filing a Medicare Appeals Council request.

Conclusion

Trying to fix placement on observation status is very difficult and generally takes a long time. Should you have questions during the process, you can call the Center for Medicare Advocacy at (860) 456-7790. Also please continue to monitor our website for updates on proposed changes to the law and on our lawsuit.

Federal Regulations
Medicare Coverage of Skilled Nursing Facility Care
42 CFR 409.30 –409.36

§ 409.30 Basic requirements.

Posthospital SNF care, including SNF–type care furnished in a hospital or CAH that has a swing-bed approval, is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31. A beneficiary in an SNF is also considered to meet the level of care requirements of § 409.31 up to and including the assessment reference date for the 5–day assessment prescribed in § 413.343(b) of this chapter, when assigned to one of the Resource Utilization Groups that is designated (in the annual publication of Federal prospective payment rates described in § 413.345 of this chapter) as representing the required level of care. For the purposes of this section, the assessment reference date is defined in accordance with § 483.315(d) of this chapter, and must occur no later than the eighth day of posthospital SNF care.

(a) Pre-admission requirements. The beneficiary must–

(1) Have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge; and

(2) Have been discharged from the hospital or CAH in or after the month he or she attained age 65, or in a month for which he or she was entitled to hospital insurance benefits on the basis of disability or end-stage renal disease, in accordance with part 406 of this chapter.

(b) Date of admission requirements. [FN1]

[1] Before December 5, 1980, the law required that admission and receipt of care be within 14 days after discharge from the hospital or CAH and permitted admission up to 28 days after discharge if a SNF bed was not available in the geographic area in which the patient lived, or at the time it would be medically appropriate to begin an active course of treatment, if SNF care would not be medically appropriate within 14 days after discharge.

(1) Except as specified in paragraph (b)(2) of this section, the beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH.

(2) The following exceptions apply–

(i) A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital or CAH, or a beneficiary enrolled in a Medicare+Choice (M+C) plan, may be admitted at the time it would be medically appropriate to begin an active course of treatment.

(ii) If, upon admission to the SNF, the beneficiary was enrolled in an M+C plan, as defined in § 422.4 of this chapter, offering the benefits described in § 422.101(c) of this chapter, the beneficiary will be considered to have met the

requirements described in paragraphs (a) and (b) of this section, and also in § 409.31(b)(2), for the duration of the SNF stay.

§ 409.31 Level of care requirement.

(a) Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) Specific conditions for meeting level of care requirements.

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition–

(i) For which the beneficiary received inpatient hospital or inpatient CAH services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or

(iii) For which, for an M+C enrollee described in § 409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

§ 409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) Services that could qualify as either skilled nursing or skilled rehabilitation services–

(1) Overall management and evaluation of care plan.

(i) When overall management and evaluation of care plan constitute skilled services. The development, management,

and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing condition–

(i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

(ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients, who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented

by physicians' orders or nursing or therapy notes.

(3) Patient education services–

(i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

(ii) Examples. A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions.

(b) Services that qualify as skilled nursing services.

(1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters

of fluid per day.

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of suprapubic catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(c) Services which would qualify as skilled rehabilitation services.

(1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in § 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

§ 409.34 Criteria for "daily basis".

(a) To meet the daily basis requirement specified in § 409.31(b)(1), the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.

§ 409.35 Criteria for "practical matter".

(a) General considerations. In making a "practical matter" determination, as required by § 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor.

Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

(b) Examples of circumstances that meet practical matter criteria–

(1) Beneficiary's condition. Inpatient care would be required “as a practical matter” if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

(2) Economy and efficiency. Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

You can access these regulations at various websites, including: www.law.cornell.edu**.**

Pertinent Federal Regulations for Medicare Appeals
42 CFR §§ 405.900 – 405.1140

§ 405.900 Basis and scope.

(a) Statutory basis. This subpart is based on the provisions of sections 1869 (a) through (e) and (g) of the Act.

(b) Scope. This subpart establishes the requirements for appeals of initial determinations for benefits under Part A or Part B of Medicare, including the following:

(1) The initial determination of whether an individual is entitled to benefits under Part A or Part B. (Regulations governing reconsiderations of these initial determinations are at 20 CFR, part 404, subpart J).

(2) The initial determination of the amount of benefits available to an individual under Part A or Part B.

(3) Any other initial determination relating to a claim for benefits under Part A or Part B, including an initial determination made by a quality improvement organization under section 1154(a)(2) of the Act or by an entity under contract with the Secretary (other than a contract under section 1852 of the Act) to administer provisions of titles XVIII or XI of the Act.

§ 405.902 Definitions.

For the purposes of this subpart, the term–

ALJ means an Administrative Law Judge of the Department of Health and Human Services.

Appellant means the beneficiary, assignee or other person or entity that has filed and pursued an appeal concerning a particular initial determination. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Appointed representative means an individual appointed by a party to represent the party in a Medicare claim or claim appeal.

Assignee means:

(1) A supplier that furnishes items or services to a beneficiary and has accepted a valid assignment of a claim or

(2) A provider or supplier that furnishes items or services to a beneficiary, who is not already a party, and has accepted a valid assignment of the right to appeal a claim executed by the beneficiary.

Assignment of a claim means the transfer by a beneficiary of his or her claim for payment to the supplier in return for the latter's promise not to charge more for his or her services than what the carrier finds to be the Medicare-approved amount, as provided in § 424.55 and § 424.56 of this chapter.

Assignment of appeal rights means the transfer by a beneficiary of his or her right to appeal under this subpart to a

provider or supplier who is not already a party, as provided in section 1869(b)(1)(C) of the Act.

Assignor means a beneficiary whose provider of services or supplier has taken assignment of a claim or an appeal of a claim.

Authorized representative means an individual authorized under State or other applicable law to act on behalf of a beneficiary or other party involved in the appeal. The authorized representative will have all of the rights and responsibilities of a beneficiary or party, as applicable, throughout the appeals process.

Beneficiary means an individual who is enrolled to receive benefits under Medicare Part A or Part B.

Carrier means an organization that has entered into a contract with the Secretary in accordance to section 1842 of the Act and is authorized to make determinations for Part B of title XVIII of the Act.

Clean claim means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under title XVIII within the time periods specified in sections 1816(c) and 1842(c) of the Act.

Contractor means an entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions.

Family member means for purposes of the QIC reconsideration panel under the following persons as they relate to the physician or healthcare provider.

(1) The spouse (other than a spouse who is legally separated from the physician or health care professional under a decree of divorce or separate maintenance);

(2) Children (including stepchildren and legally adopted children);

(3) Grandchildren;

(4) Parents; and

(5) Grandparents.

Fiscal Intermediary means an organization that has entered into a contract with CMS in accordance with section 1816 of the Act and is authorized to make determinations and payments for Part A of title XVIII of the Act, and Part B provider services as specified in § 421.5(c) of this chapter.

MAC stands for the Medicare Appeals Council within the Departmental Appeals Board of the U.S. Department of Health and Human Services.

Party means an individual or entity listed in § 405.906 that has standing to appeal an initial determination and/or a subsequent administrative appeal determination.

Provider means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that has in effect an agreement to participate in Medicare, or clinic, rehabilitation agency, or public health agency that has in effect a similar agreement, but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Qualified Independent Contractor (QIC) means an entity which contracts with the Secretary in accordance with section 1869 of the Act to perform reconsiderations under § 405.960 through § 405.978.

Quality Improvement Organization (QIO) means an entity that contracts with the Secretary in accordance with

sections 1152 and 1153 of the Act and 42 CFR subchapter F, to perform the functions described in section 1154 of the Act and 42 CFR subchapter F, including expedited determinations as described in § 405.1200 through § 405.1208.

Reliable evidence means evidence that is relevant, credible, and material.

Remand means to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

Similar fault means to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim as defined in part 411 of this chapter.

Supplier means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under Medicare.

Vacate means to set aside a previous action.

§ 405.906 Parties to the initial determinations, redeterminations, reconsiderations, hearings and reviews.

(a) Parties to the initial determination. The parties to the initial determination are the following individuals and entities:

(1) A beneficiary who files a claim for payment under Medicare Part A or Part B or has had a claim for payment filed on his or her behalf, or in the case of a deceased beneficiary, when there is no estate, any person obligated to make or entitled to receive payment in accordance with part 424, subpart E of this chapter. Payment by a third party payer does not entitle that entity to party status.

(2) A supplier who has accepted assignment for items or services furnished to a beneficiary that are at issue in the claim.

(3) A provider of services who files a claim for items or services furnished to a beneficiary.

(b) Parties to the redetermination, reconsideration, hearing and MAC. The parties to the redetermination, reconsideration, hearing, and MAC review are–

(1) The parties to the initial determination in accordance with paragraph (a) of this section, except under paragraph (a)(1) of this section where a beneficiary has assigned appeal rights under § 405.912;

(2) A State agency in accordance with § 405.908;

(3) A provider or supplier that has accepted an assignment of appeal rights from the beneficiary according to § 405.912;

(4) A non-participating physician not billing on an assigned basis who, in accordance with section 1842(l) of the Act, may be liable to refund monies collected for services furnished to the beneficiary because those services were denied on the basis of section 1862(a)(1) of the Act; and

(5) A non-participating supplier not billing on an assigned basis who, in accordance with sections 1834(a)(18) and 1834(j)(4) of the Act, may be liable to refund monies collected for items furnished to the beneficiary.

(c) Appeals by providers and suppliers when there is no other party available. If a provider or supplier is not already a party to the proceeding in accordance with paragraphs (a) and (b) of this section, a provider of services or supplier may appeal an initial determination relating to services it rendered to a beneficiary who subsequently dies if there is no other party available to appeal the determination.

§ 405.910 Appointed representatives.

(a) Scope of representation. An appointed representative may act on behalf of an individual or entity in exercising his or her right to an initial determination or appeal. Appointed representatives do not have party status and may take action only on behalf of the individual or entity that they represent.

(b) Persons not qualified. A party may not name as an appointed representative, an individual who is disqualified, suspended, or otherwise prohibited by law from acting as a representative in any proceedings before DHHS, or in entitlement appeals, before SSA.

(c) Completing a valid appointment. For purposes of this subpart, an appointment of representation must:

(1) Be in writing and signed and dated by both the party and individual agreeing to be the representative;

(2) Provide a statement appointing the representative to act on behalf of the party, and in the case of a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative.

(3) Include a written explanation of the purpose and scope of the representation;

(4) Contain both the party's and appointed representative's name, phone number, and address;

(5) Identify the beneficiary's Medicare health insurance claim number;

(6) Include the appointed representative's professional status or relationship to the party;

(7) Be filed with the entity processing the party's initial determination or appeal.

(d) Curing a defective appointment of representative.

(1) If any one of the seven elements named in paragraph (c) of this section is missing from the appointment, the adjudicator should contact the party and provide a description of the missing documentation or information.

(2) Unless the defect is cured, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

(e) Duration of appointment.

(1) Unless revoked, an appointment is considered valid for 1 year from the date that the Appointment of Representative (AOR) form or other conforming written instrument contains the signatures of both the party and the appointed representative.

(2) To initiate an appeal within the 1–year time frame, the representative must file a copy of the AOR form, or other conforming written instrument, with the appeal request. Unless revoked, the representation is valid for the duration of an individual's appeal of an initial determination.

(3) For an initial determination of a Medicare Secondary Payer recovery claim, an appointment signed in connection with the party's efforts to make a claim for third party payment is valid from the date that appointment is signed for the duration of any subsequent appeal, unless the appointment is specifically revoked.

(f) Appointed representative fees.

(1) General rule. An appointed representative for a beneficiary who wishes to charge a fee for services rendered in connection with an appeal before the Secretary must obtain approval of the fee from the Secretary. Services rendered below the ALJ level are not considered proceedings before the Secretary.

(2) No fees or costs against trust funds. No award of attorney or any other representative's fees or any costs in

connection with an appeal may be made against the Medicare trust funds.

(3) Special rules for providers and suppliers. A provider or supplier that furnished the items or services to a beneficiary that are the subject of the appeal may represent that beneficiary in an appeal under this subpart, but the provider or supplier may not charge the beneficiary any fee associated with the representation. If a provider or supplier furnishes services or items to a beneficiary, the provider or supplier may not represent the beneficiary on the issues described in section 1879(a)(2) of the Act, unless the provider or supplier waives the right to payment from the beneficiary for the services or items involved in the appeal.

(4) Special rules for purposes of third party payment. The Secretary does not review fee arrangements made by a beneficiary for purposes of making a claim for third party payment (as defined in 42 CFR 411.21) even though the representation may ultimately include representation for a Medicare Secondary Payer recovery claim.

(5) Reasonableness of representative fees. In determining the reasonableness of a representative's fee, the Secretary will not apply the test specified in sections 206(a)(2) and (a)(3) of the Act.

(g) Responsibilities of an appointed representative.

(1) An appointed representative has an affirmative duty to–

(i) Inform the party of the scope and responsibilities of the representation;

(ii) Inform the party of the status of the appeal and the results of actions taken on behalf of the party, including, but not limited to, notification of appeal determinations, decisions, and further appeal rights;

(iii) Disclose to a beneficiary any financial risk and liability of a non-assigned claim that the beneficiary may have;

(iv) Not act contrary to the interest of the party; and

(v) Comply with all laws and CMS regulations, CMS Rulings, and instructions.

(2) An appeal request filed by a provider or supplier described in paragraph (f)(3) of this section must also include a statement signed by the provider or supplier stating that no financial liability is imposed on the beneficiary in connection with that representation. If applicable, the appeal request must also include a signed statement that the provider or supplier waives the right to payment from the beneficiary for services or items regarding issues described in section 1879(a)(2) of the Act.

(h) Authority of an appointed representative. An appointed representative may, on behalf of the party–

(1) Obtain appeals information about the claim to the same extent as the party;

(2) Submit evidence;

(3) Make statements about facts and law; and

(4) Make any request, or give, or receive, any notice about the appeal proceedings.

(i) Notice or request to an appointed representative.

(1) Initial determinations. When a contractor takes an action or issues an initial determination, it sends the action or notice to the party.

(2) Appeals. When a contractor, QIC, ALJ, or the MAC takes an action or issues a redetermination, reconsideration, or appeal decision, in connection with an initial determination, it sends notice of the action to the appointed representative.

(3) The contractor, QIC, ALJ or MAC sends any requests for information or evidence regarding a claim that is appealed to the appointed representative. The contractor sends any requests for information or evidence regarding ar initial determination to the party.

(4) For initial determinations and appeals involving Medicare Secondary Payer recovery claims, the adjudicator sends notices and requests to both the beneficiary and the appointed representative.

(j) Effect of notice or request to an appointed representative. A notice or request sent to the appointed representative has the same force and effect as if was sent to the party.

(k) Information available to the appointed representative. An appointed representative may obtain any and all appeals information applicable to the claim at issue that is available to the party.

(l) Delegation of appointment by appointed representative. An appointed representative may not designate another individual to act as the appointed representative of the party unless–

(1) The appointed representative provides written notice to the party of the appointed representative's intent to delegate to another individual. The notice must include:

(i) The name of the designee; and

(ii) The designee's acceptance to be obligated and comply with the requirements of representation under this subpart.

(2) The party accepts the designation as evidenced by a written statement signed by the party. This signed statement is not required when the appointed representative and designee are attorneys in the same law firm or organization.

(m) Revoking the appointment of representative.

(1) A party may revoke an appointment of representative without cause at any time.

(2) Revocation. Revocation is not effective until the adjudicator receives a signed, written statement from the party.

(3) Death of the party.

(i) The death of a party terminates the authority of the appointed representative, except as specified in paragraph (m)(3)(ii) of this section.

(ii) A party's death does not terminate an appeal that is in progress if another individual or entity may be entitled to receive or obligated to make payment for the items or services that are the subject of the appeal. The appointment of representative remains in effect for the duration of the appeal except for MSP recovery claims.

Initial Determination (Medicare Summary Notice)

§ 405.921 Notice of initial determination.

(a) Notice of initial determination sent to the beneficiary.

(1) The notice must be written in a manner calculated to be understood by the beneficiary, and sent to the last known address of the beneficiary;

(2) Content of the notice. The notice of initial determination must contain–

(i) The reasons for the determination, including whether a local medical review policy, a local coverage determination, or national coverage determination was applied;

(ii) The procedures for obtaining additional information concerning the contractor's determination, such as a specific provision of the policy, manual, law or regulation used in making the determination;

(iii) Information on the right to a redetermination if the beneficiary is dissatisfied with the outcome of the initial determination and instructions on how to request a redetermination; and

(iv) Any other requirements specified by CMS.

(b) Notice of initial determination sent to providers and suppliers.

(1) An electronic or paper remittance advice (RA) notice is the notice of initial determination sent to providers and suppliers that accept assignment. The electronic RA must comply with the format and content requirements of the standard adopted for national use by covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and related CMS manual instructions. When a paper RA is mailed, it must comply with CMS manual instructions that parallel the HIPAA data content and coding requirements.

(2) The notice of initial determination must contain:

(i) The basis for any full or partial denial determination of services or items on the claim;

(ii) Information on the right to a redetermination if the provider or supplier is dissatisfied with the outcome of the initial determination;

(iii) All applicable claim adjustment reason and remark codes to explain the determination;

(iv) The source of the RA and who may be contacted if the provider or supplier requires further information;

(v) All content requirements of the standard adopted for national use by covered entities under HIPAA; and

(vi) Any other requirements specified by CMS.

§ 405.924 Actions that are initial determinations.

(a) Applications and entitlement of individuals. SSA makes initial determinations and processes reconsiderations with respect to an individual on the following:

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance under Medicare.

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA specifies in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence).

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance, or a denial o a request for cancellation of a request for withdrawal.

(4) A determination as to whether an individual, previously determined as entitled to hospital or supplementary medical insurance, is no longer entitled to those benefits, including a determination based on nonpayment of premiums.

(b) Claims made by or on behalf of beneficiaries. The Medicare contractor makes initial determinations regarding

claims for benefits under Medicare Part A and Part B. A finding that a request for payment or other submission does not meet the requirements for a Medicare claim as defined in § 424.32 of this chapter, is not considered an initial determination. An initial determination for purposes of this subpart includes, but is not limited to, determinations with respect to:

(1) If the items and/or services furnished are covered under title XVIII;

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, if the beneficiary, or supplier who accepts assignment under § 424.55 of this chapter knew, or could reasonably have expected to know at the time the items or services were furnished, that the items or services were not covered;

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, if the beneficiary or physician knew, or could reasonably have expected to know at the time the services were furnished, that the services were not covered;

(4) Whether the deductible is met;

(5) The computation of the coinsurance amount;

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care;

(7) Periods of hospice care used;

(8) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, and partial hospitalization services;

(9) The beginning and ending of a spell of illness, including a determination made under the presumptions established under § 409.60(c)(2) of this chapter, and as specified in § 409.60(c)(4) of this chapter;

(10) The medical necessity of services, or the reasonableness or appropriateness of placement of an individual at an acute level of patient care made by the Quality Improvement Organization (QIO) on behalf of the contractor in accordance with § 476.86(c)(1) of this chapter;

(11) Any other issues having a present or potential effect on the amount of benefits to be paid under Part A or Part B of Medicare, including a determination as to whether there was an underpayment of benefits paid under Part A or Part B, and if so, the amount thereof;

(12) If a waiver of adjustment or recovery under sections 1870(b) and (c) of the Act is appropriate:

(i) When an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) was made for an individual; or

(ii) For a Medicare Secondary Payer recovery claim against a beneficiary or against a provider or supplier.

(13) If a particular claim is not payable by Medicare based upon the application of the Medicare Secondary Payer provisions of section 1862(b) of the Act.

(14) Under the Medicare Secondary Payer provisions of sections 1862(b) of the Act that Medicare has a recovery claim against a provider, supplier, or beneficiary for services or items that were already paid by the Medicare program, except when the Medicare Secondary Payer recovery claim against the provider or supplier is based upon failure to file a proper claim as defined in part 411 of this chapter because this action is a reopening.

(c) Determinations by QIOs. An initial determination for purposes of this subpart also includes a determination made by a QIO that:

(1) A provider can terminate services provided to an individual when a physician certified that failure to continue the

provision of those services is likely to place the individual's health at significant risk; or

(2) A provider can discharge an individual from the provider of services.

§ 405.928 Effect of the initial determination.

(a) An initial determination described in § 405.924(a) is binding unless it is revised or reconsidered in accordance with 20 CFR 404.907, or revised as a result of a reopening in accordance with 20 CFR 404.988.

(b) An initial determination described in § 405.924(b) is binding upon all parties to the initial determination unless–

(1) A redetermination is completed in accordance with § 405.940 through § 405.958; or

(2) The initial determination is revised as a result of a reopening in accordance with § 405.980.

(c) An initial determination listed in § 405.924(b) where a party submits a timely, valid request for redetermination under § 405.942 through § 405.944 must be processed as a redetermination under § 405.948 through § 405.958 unless the initial determination involves a clerical error or other minor error or omission.

Redetermination

§ 405.940 Right to a redetermination.

A person or entity that may be a party to a redetermination in accordance with and that is dissatisfied with an initial determination may request a redetermination by a contractor in accordance with § 405.940 through § 405.958, regardless of the amount in controversy.

§ 405.942 Time frame for filing a request for a redetermination.

(a) Time frame for filing a request. Except as provided in paragraph (b) of this section, any request for redetermination must be filed within 120 calendar days from the date a party receives the notice of the initial determination.

(1) For purposes of this section, the date of receipt of the initial determination will be presumed to be 5 calendar days after the date of the notice of initial determination, unless there is evidence to the contrary.

(2) The request is considered as filed on the date it is received by the contractor.

(b) Extending the time frame for filing a request. General rule. If the 120 calendar day period in which to file a request for a redetermination has expired and a party shows good cause, the contractor may extend the time frame for filing a request for redetermination.

(1) How to request an extension. A party may file a request for an extension of time for filing a request for a redetermination with the contractor. The party should include any evidence supporting the request for extension. The request for redetermination extension must–

(i) Be in writing;

(ii) State why the request for redetermination was not filed within the required time frame; and

(iii) Meet the requirements of § 405.944.

(2) How the contractor determines if good cause exists. In determining if a party has good cause for missing a deadline to request a redetermination, the contractor considers–

(i) The circumstances that kept the party from making the request on time;

(ii) If the contractor's action(s) misled the party; and

(iii) If the party had or has any physical, mental, educational, or linguistic limitations, including any lack of facility with the English language, that prevented the party from filing a timely request or from understanding or knowing about the need to file a timely request.

(3) Examples of good cause. Examples of circumstances when good cause may be found to exist include, but are not limited to, the following situations:

(i) The party was prevented by serious illness from contacting the contractor in person, in writing, or through a friend, relative, or other person; or

(ii) The party had a death or serious illness in his or her immediate family; or

(iii) Important records of the party were destroyed or damaged by fire or other accidental cause; or

(iv) The contractor gave the party incorrect or incomplete information about when and how to request a redetermination; or

(v) The party did not receive notice of the determination or decision; or

(vi) The party sent the request to a Government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired.

§ 405.944 Place and method of filing a request for a redetermination.

(a) Filing location. The request for redetermination must be filed with the contractor indicated on the notice of initial determination.

(b) Content of redetermination request. The request for redetermination must be in writing and should be made on a standard CMS form. A written request that is not made on a standard CMS form is accepted if it contains the same required elements as follows:

(1) The beneficiary's name;

(2) The Medicare health insurance claim number;

(3) Specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of the service;

(4) The name and signature of the party or the representative of the party.

(c) Requests for redetermination by more than one party. If more than one party timely files a request for redetermination on the same claim before a redetermination is made on the first timely filed request, the contractor must consolidate the separate requests into one proceeding and issue one redetermination.

§ 405.946 Evidence to be submitted with the redetermination request.

(a) Evidence submitted with the request. When filing the request for redetermination, a party must explain why it disagrees with the contractor's determination and should include any evidence that the party believes should be considered by the contractor in making its redetermination.

(b) Evidence submitted after the request. When a party submits additional evidence after filing the request for redetermination, the contractor's 60 calendar day decision-making time frame is automatically extended for up to 14 calendar days for each submission.

§ 405.948 Conduct of a redetermination.

A redetermination consists of an independent review of an initial determination. In conducting a redetermination, the contractor reviews the evidence and findings upon which the initial determination was based, and any additional evidence the parties submit or the contractor obtains on its own. An individual who was not involved in making the initial determination must make a redetermination. The contractor may raise and develop new issues that are relevant to the claims in the particular case.

§ 405.950 Time frame for making a redetermination.

(a) General rule. The contractor mails, or otherwise transmits, written notice of the redetermination or dismissal to the parties to the redetermination at their last known addresses within 60 calendar days of the date the contractor receives a timely filed request for redetermination.

(b) Exceptions.

(1) If a contractor grants an appellant's request for an extension of the 120 calendar day filing deadline made in accordance with § 405.942(b), the 60 calendar day decision-making time frame begins on the date the contractor receives the late-filed request for redetermination, or when the request for an extension is granted, whichever is later.

(2) If a contractor receives from multiple parties timely requests for redetermination of a claim determination, consistent with § 405.944(c), the contractor must issue a redetermination or dismissal within 60 calendar days of the latest filed request.

(3) If a party submits additional evidence after the request for redetermination is filed, the contractor's 60 calendar day decision-making time frame is extended for up to 14 calendar days for each submission, consistent with § 405.946(b).

§ 405.954 Redetermination.

Upon the basis of the evidence of record, the contractor adjudicates the claim(s), and renders a redetermination affirming or reversing, in whole or in part, the initial determination in question.

§ 405.956 Notice of a redetermination.

(a) Notification to parties.

(1) General rule. Written notice of a redetermination affirming, in whole or in part, the initial determination must be mailed or otherwise transmitted to all parties at their last known addresses in accordance with the time frames established in § 405.950. Written notice of a redetermination fully reversing the initial determination must be mailed or otherwise transmitted to the appellant in accordance with the time frames established in § 405.950. If the redetermination results in issuance of supplemental payment to a provider or supplier, the Medicare contractor must also issue an electronic or paper RA notice to the provider or supplier.

(2) Overpayment cases involving multiple beneficiaries who have no liability. In an overpayment case involving multiple beneficiaries who have no liability, the contractor may issue a written notice only to the appellant.

(b) Content of the notice for affirmations, in whole or in part. For decisions that are affirmations, in whole or in part, of the initial determination, the redetermination must be written in a manner calculated to be understood by a beneficiary, and contain–

(1) A clear statement indicating the extent to which the redetermination is favorable or unfavorable;

(2) A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

(3) An explanation of how pertinent laws, regulations, coverage rules, and CMS policies apply to the facts of the case;

(4) A summary of the rationale for the redetermination in clear, understandable language;

(5) Notification to the parties of their right to a reconsideration and a description of the procedures that a party must follow in order to request a reconsideration, including the time frame within which a reconsideration must be requested;

(6) A statement of any specific missing documentation that must be submitted with a request for a reconsideration, if applicable;

(7) A statement that all evidence the appellant wishes to introduce during the claim appeals process should be submitted with the request for a reconsideration;

(8) Notification that evidence not submitted to the QIC as indicated in paragraph (b)(6) of this section, is not considered at an ALJ hearing or further appeal, unless the appellant demonstrates good cause as to why that evidence was not provided previously; and

(9) The procedures for obtaining additional information concerning the redetermination, such as specific provisions of the policy, manual, or regulation used in making the redetermination.

(10) Any other requirements specified by CMS.

(c) Content of the notice for a full reversal. For decisions that are full reversals of the initial determination, the redetermination must be in writing and contain–

(1) A clear statement indicating that the redetermination is wholly favorable;

(2) Any other requirements specified by CMS.

(d) Exception for beneficiary appeal requests.

(1) The notice must inform beneficiary appellants that the requirements of paragraph (b)(8) of this section are not applicable for purposes of beneficiary appeals.

(2) This exception does not apply for appeal requests from beneficiaries who are represented by providers or suppliers.

§ 405.958 Effect of a redetermination.

In accordance with section 1869(a)(3)(D) of the Act, once a redetermination is issued, it becomes part of the initial determination. The redetermination is binding upon all parties unless–

(a) A reconsideration is completed in accordance with § 405.960 through § 405.978; or

(b) The redetermination is revised as a result of a reopening in accordance with § 405.980.

Reconsideration

§ 405.962 Timeframe for filing a request for a reconsideration.

(a) Timeframe for filing a request. Except as provided in paragraph (b) of this section and in § 405.974(b)(1), regarding a request for QIC reconsideration of a contractor's dismissal of a redetermination request, any request for a reconsideration must be filed within 180 calendar days from the date the party receives the notice of the redetermination.

(1) For purposes of this section, the date of receipt of the redetermination will be presumed to be 5 calendar days after the date of the notice of redetermination, unless there is evidence to the contrary.

(2) For purposes of meeting the 180 calendar day filing deadline, the request is considered as filed on the date it is received by the QIC.

(b) Extending the time for filing a request.

(1) General rule. A QIC may extend the 180 calendar day timeframe for filing a request for reconsideration for good cause.

(2) How to request an extension. A party to the redetermination must file its request for an extension of the time for filing the reconsideration request with its request for reconsideration. A party should include evidence to support the request for extension. The request for reconsideration and request for extension must–

(i) Be in writing;

(ii) State why the request for reconsideration was not filed within the required timeframe; and

(iii) Meet the requirements of § 405.964.

(3) How the QIC determines whether good cause exists. In determining whether a party has good cause for missing a deadline to request reconsideration, the QIC applies the good cause provisions contained in § 405.942(b)(2) and (b)(3).

§ 405.964 Place and method of filing a request for a reconsideration.

(a) Filing location. The request for reconsideration must be filed with the QIC indicated on the notice of redetermination.

(b) Content of reconsideration request. The request for reconsideration must be in writing and should be made on a standard CMS form. A written request that is not made on a standard CMS form is accepted if it contains the same required elements, as follows:

(1) The beneficiary's name;

(2) Medicare health insurance claim number;

(3) Specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;

(4) The name and signature of the party or the representative of the party; and

(5) The name of the contractor that made the redetermination.

(c) Requests for reconsideration by more than one party. If more than one party timely files a request for reconsideration on the same claim before a reconsideration is made on the first timely filed request, the QIC must consolidate the separate requests into one proceeding and issue one reconsideration.

§ 405.966 Evidence to be submitted with the reconsideration request.

(a) Evidence submitted with the request. When filing a request for reconsideration, a party should present evidence and allegations of fact or law related to the issue in dispute and explain why it disagrees with the initial determination, including the redetermination.

(1) This evidence must include any missing documentation identified in the notice of redetermination, consistent with § 405.956(b)(6).

(2) Absent good cause, failure to submit all evidence, including documentation requested in the notice of redetermination prior to the issuance of the notice of reconsideration precludes subsequent consideration of that evidence.

(b) Evidence submitted after the request. Each time a party submits additional evidence after filing the request for reconsideration, the QIC's 60 calendar day decisionmaking timeframe is automatically extended by up to 14 calendar days for each submission. This extension does not apply to timely submissions of documentation specifically requested by a QIC, unless the documentation was originally requested in the notice of redetermination.

(c) Exception for beneficiaries and State Medicaid Agencies that file reconsideration requests.

(1) Beneficiaries and State Medicaid Agencies that file requests for reconsideration are not required to comply with the requirements of paragraph (a) of this section. However, the automatic 14 calendar day extension described in paragraph (b) of this section applies to each evidence submission made after the request for reconsideration is filed.

(2) Beneficiaries who are represented by providers or suppliers must comply with the requirements of paragraph (a) of this section.

§ 405.968 Conduct of a reconsideration.

(a) General rules.

(1) A reconsideration consists of an independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim. In conducting a reconsideration, the QIC reviews the evidence and findings upon which the initial determination, including the redetermination, was based, and any additional evidence the parties submit or that the QIC obtains on its own. If the initial determination involves a finding on whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A) of the Act), a QIC's reconsideration must involve consideration by a panel of physicians or other appropriate health care professionals, and be based on clinical experience, the patient's medical records, and medical, technical, and scientific evidence of record to the extent applicable.

(b) Authority of the QIC.

(1) National coverage determinations (NCDs), CMS Rulings, and applicable laws and regulations are binding on the QIC.

(2) QICs are not bound by LCDs, LMRPs, or CMS program guidance, such as program memoranda and manual instructions, but give substantial deference to these policies if they are applicable to a particular case. A QIC may decline to follow a policy, if the QIC determines, either at a party's request or at its own discretion, that the policy does not apply to the facts of the particular case.

(3) If a QIC declines to follow a policy in a particular case, the QIC's reconsideration explains the reasons why the policy was not followed.

(4) A QIC's decision to decline to follow a policy under this section applies only to the specific claim being reconsidered and does not have precedential effect.

(5) A QIC may raise and develop new issues that are relevant to the claims in a particular case provided that the contractor rendered a redetermination with respect to the claims.

(c) Qualifications of the QIC's panel members.

(1) Members of a QIC's panel who conduct reconsiderations must have sufficient medical, legal, and other expertise, including knowledge of the Medicare program.

(2) When a redetermination is made with respect to whether an item or service is reasonable and necessary (section 1862(a)(1)(A) of the Act), the QIC designates a panel of physicians or other appropriate health care professionals to consider the facts and circumstances of the redetermination.

(3) Where a claim pertains to the furnishing of treatment by a physician, or the provision of items or services by a physician, a reviewing professional must be a physician.

(d) Disqualification of a QIC panel member. No physician or health care professional employed by or otherwise working for a QIC may review determinations regarding–

(1) Health care services furnished to a patient if that physician or health care professional was directly responsible for furnishing those services; or

(2) Health care services provided in or by an institution, organization, or agency, if that physician or health care professional or any member of the physician's family or health care professional's family has, directly or indirectly, a significant financial interest in that institution, organization, or agency (see the term family member as defined in § 405.902).

§ 405.970 Timeframe for making a reconsideration.

(a) General rule. Within 60 calendar days of the date the QIC receives a timely filed request for reconsideration or any additional time provided by paragraph (b) of this section, the QIC mails, or otherwise transmits to the parties at their last known addresses, written notice of–

(1) The reconsideration;

(2) Its inability to complete its review within 60 calendar days in accordance with paragraphs (c) through (e) of this section; or

(3) Dismissal.

(b) Exceptions.

(1) If a QIC grants an appellant's request for an extension of the 180 calendar day filing deadline made in accordance with § 405.962(b), the QIC's 60 calendar day decision-making timeframe begins on the date the QIC receives the late filed request for reconsideration, or when the request for an extension that meets the requirements of § 405.962(b) is granted, whichever is later.

(2) If a QIC receives timely requests for reconsideration from multiple parties, consistent with § 405.964(c), the QIC must issue a reconsideration, notice that it cannot complete its review, or dismissal within 60 calendar days for each submission of the latest filed request.

(3) Each time a party submits additional evidence after the request for reconsideration is filed, the QIC's 60 calendar day decisionmaking timeframe is extended by up to 14 calendar days for each submission, consistent with § 405.966(b).

(c) Responsibilities of the QIC. Within 60 calendar days of receiving a request for a reconsideration, or any additional time provided for under paragraph (b) of this section, a QIC must take one of the following actions:

(1) Notify all parties of its reconsideration, consistent with § 405.976.

(2) Notify the parties that it cannot complete the reconsideration by the deadline specified in paragraph (b) of this section and offer the appellant the opportunity to escalate the appeal to an ALJ. The QIC continues to process the reconsideration unless it receives a written request from the appellant to escalate the case to an ALJ after the adjudication period has expired.

(3) Notify all parties that it has dismissed the request for reconsideration consistent with § 405.972.

[1] The official CFR appears to have inadvertently deleted subsection (c)(3). See 70 FR 11482.

(d) Responsibilities of the appellant. If an appellant wishes to exercise the option of escalating the case to an ALJ, the appellant must notify the QIC in writing.

(e) Actions following appellant's notice.

(1) If the appellant fails to notify the QIC, or notifies the QIC that the appellant does not choose to escalate the case, the QIC completes its reconsideration and notifies the appellant of its action consistent with § 405.972 or § 405.976.

(2) If the appellant notifies the QIC that the appellant wishes to escalate the case, the QIC must take one of the following actions within 5 calendar days of receipt of the notice or 5 calendar days from the end of the applicable adjudication period under paragraph (a) or (b) of this section:

(i) Complete its reconsideration and notify all parties of its decision consistent with § 405.972 or § 405.976.

(ii) Acknowledge the escalation notice in writing and forward the case file to the ALJ hearing office.

§ 405.974 Reconsideration.

(a) Reconsideration of a contractor determination. Except as provided in § 405.972, upon the basis of the evidence of record, the QIC must issue a reconsideration affirming or reversing, in whole or in part, the initial determination, including the redetermination, in question.

(b) Reconsideration of contractor's dismissal of a redetermination request.

(1) A party to a contractor's dismissal of a request for redetermination has a right to have the dismissal reviewed by a QIC, if the party files a written request for review of the dismissal with the QIC within 60 calendar days after receipt of the contractor's notice of dismissal.

(i) For purposes of this section, the date of receipt of the contractor's notice of dismissal is presumed to be 5 calendar days after the date of the notice of dismissal, unless there is evidence to the contrary.

(ii) For purposes of meeting the 60 calendar day filing deadline, the request is considered as filed on the date it is received by the QIC indicated on the notice of dismissal.

(2) If the QIC determines that the contractor's dismissal was in error, it vacates the dismissal and remands the case to the contractor for a redetermination.

(3) A QIC's reconsideration of a contractor's dismissal of a redetermination request is binding and not subject to further review.

§ 405.976 Notice of a reconsideration.

(a) Notification to parties.

(1) General rules.

(i) Written notice of the reconsideration must be mailed or otherwise transmitted to all parties at their last known addresses, in accordance with the timeframes established in § 405.970(a) or (b).

(ii) The notice must be written in a manner reasonably calculated to be understood by a beneficiary.

(iii) The QIC must promptly notify the entity responsible for payment of claims under Part A or Part B of its

reconsideration. If the reconsideration results in issuance of supplemental payment to a provider or supplier, the Medicare contractor must also issue an electronic or paper RA notice to the provider or supplier.

(2) Overpayment cases involving multiple beneficiaries who have no liability. In an overpayment case involving multiple beneficiaries who have no liability, the QIC may issue a written notice only to the appellant.

(b) Content of the notice. The reconsideration must be in writing and contain–

(1) A clear statement indicating whether the reconsideration is favorable or unfavorable;

(2) A summary of the facts, including as appropriate, a summary of the clinical or scientific evidence used in making the reconsideration;

(3) An explanation of how pertinent laws, regulations, coverage rules, and CMS policies, apply to the facts of the case, including, where applicable, the rationale for declining to follow an LCD, LMRP, or CMS program guidance;

(4) In the case of a determination on whether an item or service is reasonable or necessary under section 1862(a)(1)(A) of the Act, an explanation of the medical and scientific rationale for the decision;

(5) A summary of the rationale for the reconsideration.

(i) If the notice of redetermination indicated that specific documentation should be submitted with the reconsideration request, and the documentation was not submitted with the request for reconsideration, the summary must indicate how the missing documentation affected the reconsideration; and

(ii) The summary must also specify that, consistent with § 405.956(b)(8) and § 405.966(b), all evidence, including evidence requested in the notice of redetermination, that is not submitted prior to the issuance of the reconsideration will not be considered at an ALJ level, or made part of the administrative record, unless the appellant demonstrates good cause as to why the evidence was not provided prior to the issuance of the QIC's reconsideration. This requirement does not apply to beneficiaries, unless the beneficiary is represented by a provider or supplier or to State Medicaid Agencies;

(6) Information concerning to the parties' right to an ALJ hearing, including the applicable amount in controversy requirement and aggregation provisions;

(7) A statement of whether the amount in controversy needed for an ALJ hearing is met when the reconsideration is partially or fully unfavorable;

(8) A description of the procedures that a party must follow in order to obtain an ALJ hearing of an expedited reconsideration, including the time frame under which a request for an ALJ hearing must be filed;

(9) If appropriate, advice as to the requirements for use of the expedited access to judicial review process set forth in § 405.990;

(10) The procedures for obtaining additional information concerning the reconsideration, such as specific provisions of the policy, manual, or regulation used in making the reconsideration; and

(11) Any other requirements specified by CMS.

§ 405.978 Effect of a reconsideration.

A reconsideration is binding on all parties, unless–

(a) An ALJ decision is issued in accordance to a request for an ALJ hearing made in accordance with § 405.1014;

(b) A review entity issues a decision in accordance to a request for expedited access to judicial review under §

405.990; or

(c) The reconsideration is revised as a result of a reopening in accordance with § 405.980.

§ 405.986 Good cause for reopening.

(a) Establishing good cause. Good cause may be established when–

(1) There is new and material evidence that–

(i) Was not available or known at the time of the determination or decision; and

(ii) May result in a different conclusion; or

(2) The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

(b) Change in substantive law or interpretative policy. A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, or a change in legal interpretation or policy by SSA in a regulation, SSA ruling, or SSA general instruction in entitlement appeals, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section. This provision does not preclude contractors from conducting reopenings to effectuate coverage decisions issued under the authority granted by section 1869(f) of the Act.

(c) Third party payer error. A request to reopen a claim based upon a third party payer's error in making a primary payment determination when Medicare processed the claim in accordance with the information in its system of records or on the claim form does not constitute good cause for reopening.

Administrative Law Judge Hearing

§ 405.1000 Hearing before an ALJ: General rule.

(a) If a party is dissatisfied with a QIC's reconsideration or if the adjudication period specified in § 405.970 for the QIC to complete its reconsideration has elapsed, the party may request a hearing.

(b) A hearing may be conducted in-person, by video-teleconference (VTC), or by telephone. At the hearing, the parties may submit evidence (subject to the restrictions in § 405.1018 and § 405.1028), examine the evidence used in making the determination under review, and present and/or question witnesses.

(c) In some circumstances, a representative of CMS or its contractor may participate in or join the hearing as a party. (See, § 405.1010 and § 405.1012.)

(d) The ALJ conducts a de novo review and issues a decision based on the hearing record.

(e) If all parties to the hearing waive their right to appear at the hearing in person or by telephone or video-teleconference, the ALJ may make a decision based on the evidence that is in the file and any new evidence that is submitted for consideration.

(f) The ALJ may require the parties to participate in a hearing if it is necessary to decide the case. If the ALJ determines that it is necessary to obtain testimony from a non-party, he or she may hold a hearing to obtain that testimony, even if all of the parties have waived the right to appear. In that event, however, the ALJ will give the parties the opportunity to appear when the testimony is given, but may hold the hearing even if none of the parties decide to appear.

(g) An ALJ may also issue a decision on the record on his or her own initiative if the evidence in the hearing record

supports a fully favorable finding.

§ 405.1002 Right to an ALJ hearing.

(a) A party to a QIC reconsideration may request a hearing before an ALJ if–

(1) The party files a written request for an ALJ hearing within 60 calendar days after receipt of the notice of the QIC's reconsideration.

(2) The party meets the amount in controversy requirements of § 405.1006.

(3) For purposes of this section, the date of receipt of the reconsideration is presumed to be 5 calendar days after the date of the reconsideration, unless there is evidence to the contrary.

(4) For purposes of meeting the 60 calendar day filing deadline, the request is considered as filed on the date it is received by the entity specified in the QIC's reconsideration.

(b) A party who files a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the period described in § 405.970 has a right to a hearing before an ALJ if–

(1) The party files a written request with the QIC to escalate the appeal to the ALJ level after the period described in § 405.970(a) and (b) has expired and the party files the request in accordance with § 405.970(d);

(2) The QIC does not issue a decision or dismissal order within 5 calendar days of receiving the request for escalation in accordance with § 405.970(e)(2); and

(3) The party has an amount remaining in controversy specified in § 405.1006.

§ 405.1004 Right to ALJ review of QIC notice of dismissal.

(a) A party to a QIC's dismissal of a request for reconsideration has a right to have the dismissal reviewed by an ALJ if–

(1) The party files a written request for an ALJ review within 60 calendar days after receipt of the notice of the QIC's dismissal.

(2) The party meets the amount in controversy requirements of § 405.1006.

(3) For purposes of this section, the date of receipt of the QIC's dismissal is presumed to be 5 calendar days after the date of the dismissal notice, unless there is evidence to the contrary.

(4) For purposes of meeting the 60 calendar day filing deadline, the request is considered as filed on the date it is received by the entity specified in the QIC's dismissal.

(b) If the ALJ determines that the QIC's dismissal was in error, he or she vacates the dismissal and remands the case to the QIC for a reconsideration.

(c) An ALJ's decision regarding a QIC's dismissal of a reconsideration request is binding and not subject to further review. The dismissal of a request for ALJ review of a QIC's dismissal of a reconsideration request is binding and not subject to further review, unless vacated by the MAC under § 405.1108(b).

§ 405.1006 Amount in controversy required to request an ALJ hearing and judicial review.

(a) Definitions. For the purposes of aggregating claims to meet the amount in controversy requirement for an ALJ hearing or judicial review:

(1) “Common issues of law and fact” means the claims sought to be aggregated are denied, or payment is reduced, for similar reasons and arise from a similar fact pattern material to the reason the claims are denied or payment is reduced.

(2) “Delivery of similar or related services” means like or coordinated services or items provided to one or more beneficiaries.

(b) ALJ review. To be entitled to a hearing before an ALJ, the party must meet the amount in controversy requirements of this section.

(1) For ALJ hearing requests, the required amount remaining in controversy must be $100 increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as measured from July 2003 to the July preceding the current year involved.

(2) If the figure in paragraph (b)(1) of this section is not a multiple of $10, then it is rounded to the nearest multiple of $10. The Secretary will publish changes to the amount in controversy requirement in the Federal Register when necessary.

(c) Judicial review. To be entitled to judicial review, a party must meet the amount in controversy requirements of this subpart at the time it requests judicial review.

(1) For review requests, the required amount remaining in controversy must be $1,000 or more, adjusted as specified in paragraphs (b)(1) and (b)(2) of this section.

(2) [Reserved]

(d) Calculating the amount remaining in controversy.

(1) The amount remaining in controversy is computed as the actual amount charged the individual for the items and services in question, reduced by–

(i) Any Medicare payments already made or awarded for the items or services; and

(ii) Any deductible and coinsurance amounts applicable in the particular case.

(2) Notwithstanding paragraph (d)(1) of this section, when payment is made for items or services under section 1879 of the Act or § 411.400 of this chapter, or the liability of the beneficiary for those services is limited under § 411.402 of this chapter, the amount in controversy is computed as the amount that the beneficiary would have been charged for the items or services in question if those expenses were not paid under § 411.400 of this chapter or if that liability was not limited under § 411.402 of this chapter, reduced by any deductible and coinsurance amounts applicable in the particular case.

(e) Aggregating claims to meet the amount in controversy–

(1) Appealing QIC reconsiderations to the ALJ level. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the amount in controversy for an ALJ hearing if–

(i) The claims were previously reconsidered by a QIC;

(ii) The request for ALJ hearing lists all of the claims to be aggregated and is filed within 60 calendar days after receipt of all of the reconsiderations being appealed; and

(iii) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the amount in controversy requirements.

(2) Aggregating claims that are escalated from the QIC level to the ALJ level. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the amount in controversy for an ALJ hearing if–

(i) The claims were pending before the QIC in conjunction with the same request for reconsideration;

(ii) The appellant(s) requests aggregation of the claims to the ALJ level in the same request for escalation; and

(iii) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the amount in controversy requirements.

(f) Content of request for aggregation. When an appellant(s) seeks to aggregate claims in a request for an ALJ hearing, the appellant(s) must–

(1) Specify all of the claims the appellant(s) seeks to aggregate; and

(2) State why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services.

§ 405.1008 Parties to an ALJ hearing.

(a) Who may request a hearing? Any party to the QIC's reconsideration may request a hearing before an ALJ. However, only the appellant (that is, the party that filed and maintained the request for reconsideration by a QIC) may request that the appeal be escalated to the ALJ level if the QIC does not complete its action within the time frame described in § 405.970.

(b) Who are parties to the ALJ hearing. The party who filed the request for hearing and all other parties to the reconsideration are parties to the ALJ hearing. In addition, a representative of CMS or its contractor may be a party under the circumstances described in § 405.1012.

§ 405.1014 Request for an ALJ hearing.

(a) Content of the request. The request for an ALJ hearing must be made in writing. The request must include all of the following–

(1) The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed.

(2) The name and address of the appellant, when the appellant is not the beneficiary.

(3) The name and address of the designated representatives if any.

(4) The document control number assigned to the appeal by the QIC, if any.

(5) The dates of service.

(6) The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed.

(7) A statement of any additional evidence to be submitted and the date it will be submitted.

(b) When and where to file. The request for an ALJ hearing after a QIC reconsideration must be filed–

(1) Within 60 calendar days from the date the party receives notice of the QIC's reconsideration;

(2) With the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other parties. Failure to do so will toll the ALJ's 90 calendar day adjudication deadline until all parties to

the QIC reconsideration receive notice of the requested ALJ hearing. If the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the deadline specified in § 405.1016 for deciding the appeal begins on the date the entity specified in the QIC's reconsideration receives the request for hearing. If the request for hearing is filed with an entity, other than the entity specified in the QIC's reconsideration, the ALJ hearing office must notify the appellant of the date of receipt of the request and the commencement of the 90 calendar day adjudication time frame.

(c) Extension of time to request a hearing.

(1) If the request for hearing is not filed within 60 calendar days of receipt of the QIC's reconsideration, an appellant may request an extension for good cause (See §§ 405.942(b)(2) and 405.942(b)(3)).

(2) Any request for an extension of time must be in writing, give the reasons why the request for a hearing was not filed within the stated time period, and must be filed with the entity specified in the notice of reconsideration.

(3) If the ALJ finds there is good cause for missing the deadline, the time period for filing the hearing request will be extended. To determine whether good cause for late filing exists, the ALJ uses the standards set forth in § 405.942(b)(2) and § 405.942(b)(3).

(4) If a request for hearing is not timely filed, the adjudication period in § 405.1016 begins the date the ALJ grants the request to extend the filing deadline

§ 405.1016 Time frames for deciding an appeal before an ALJ.

(a) When a request for an ALJ hearing is filed after a QIC has issued a reconsideration, the ALJ must issue a decision, dismissal order, or remand to the QIC, as appropriate, no later than the end of the 90 calendar day period beginning on the date the request for hearing is received by the entity specified in the QIC's notice of reconsideration, unless the 90 calendar day period has been extended as provided in this subpart.

(b) The adjudication period specified in paragraph (a) of this section begins on the date that a timely filed request for hearing is received by the entity specified in the QIC's reconsideration, or, if it is not timely filed, the date that the ALJ grants any extension to the filing deadline.

(c) When an appeal is escalated to the ALJ level because the QIC has not issued a reconsideration determination within the period specified in § 405.970, the ALJ must issue a decision, dismissal order, or remand to the QIC, as appropriate, no later than the end of the 180 calendar day period beginning on the date that the request for escalation is received by the ALJ hearing office, unless the 180 calendar day period is extended as provided in this subpart.

(d) When CMS or its contractor is a party to an ALJ hearing and a party requests discovery under § 405.1037 against another party to the hearing, the adjudication periods discussed in paragraphs (a) and (c) of this section are tolled.

§ 405.1018 Submitting evidence before the ALJ hearing.

(a) Except as provided in this section, parties must submit all written evidence they wish to have considered at the hearing with the request for hearing (or within 10 calendar days of receiving the notice of hearing).

(b) If a party submits written evidence later than 10 calendar days after receiving the notice of hearing, the period between the time the evidence was required to have been submitted and the time it is received is not counted toward the adjudication deadline specified in § 405.1016.

(c) Any evidence submitted by a provider, supplier, or beneficiary represented by a provider or supplier that is not submitted prior to the issuance of the QIC's reconsideration determination must be accompanied by a statement explaining why the evidence was not previously submitted to the QIC, or a prior decision-maker (see § 405.1028).

(d) The requirements of this section do not apply to oral testimony given at a hearing, or to evidence submitted by an unrepresented beneficiary.

§ 405.1020 Time and place for a hearing before an ALJ.

(a) General. The ALJ sets the time and place for the hearing, and may change the time and place, if necessary.

(b) Determining how appearances are made. The ALJ will direct that the appearance of an individual be conducted by videoteleconferencing (VTC) if the ALJ finds that VTC technology is available to conduct the appearance. The ALJ may also offer to conduct a hearing by telephone if the request for hearing or administrative record suggests that a telephone hearing may be more convenient for one or more of the parties. The ALJ, with the concurrence of the Managing Field Office ALJ, may determine that an in-person hearing should be conducted if–

(1) VTC technology is not available; or

(2) Special or extraordinary circumstances exist.

(c) Notice of hearing.

(1) The ALJ sends a notice of hearing to all parties that filed an appeal or participated in the reconsideration, any party who was found liable for the services at issue subsequent to the initial determination, and the QIC that issued the reconsideration, advising them of the proposed time and place of the hearing.

(2) The notice of hearing will require all parties to the ALJ hearing (and any potential participant from CMS or its contractor who wishes to attend the hearing) to reply to the notice by:

(i) Acknowledging whether they plan to attend the hearing at the time and place proposed in the notice of hearing; or

(ii) Objecting to the proposed time and/or place of the hearing.

(d) A party's right to waive a hearing. A party may also waive the right to a hearing and request that the ALJ issue a decision based on the written evidence in the record. As provided in § 405.1000, the ALJ may require the parties to attend a hearing if it is necessary to decide the case. If the ALJ determines that it is necessary to obtain testimony from a non-party, he or she may still hold a hearing to obtain that testimony, even if all of the parties have waived the right to appear. In those cases, the ALJ will give the parties the opportunity to appear when the testimony is given but may hold the hearing even if none of the parties decide to appear.

(e) A party's objection to time and place of hearing.

(1) If a party objects to the time and place of the hearing, the party must notify the ALJ at the earliest possible opportunity before the time set for the hearing.

(2) The party must state the reason for the objection and state the time and place he or she wants the hearing to be held.

(3) The request must be in writing.

(4) The ALJ may change the time or place of the hearing if the party has good cause. (Section 405.1052(a)(2) provides the procedures the ALJ follows when a party does not respond to a notice of hearing and fails to appear at the time and place of the hearing.)

(f) Good cause for changing the time or place. The ALJ can find good cause for changing the time or place of the scheduled hearing and reschedule the hearing if the information available to the ALJ supports the party's contention that–

(1) The party or his or her representative is unable to attend or to travel to the scheduled hearing because of a serious physical or mental condition, incapacitating injury, or death in the family; or

(2) Severe weather conditions make it impossible to travel to the hearing; or

(3) Good cause exists as set forth in paragraph (g) of this section.

(g) Good cause in other circumstances.

(1) In determining whether good cause exists in circumstances other than those set forth in paragraph (f) of this section, the ALJ considers the party's reason for requesting the change, the facts supporting the request, and the impact of the proposed change on the efficient administration of the hearing process.

(2) Factors evaluated to determine the impact of the change include, but are not limited to, the effect on processing other scheduled hearings, potential delays in rescheduling the hearing, and whether any prior changes were granted the party.

(3) Examples of other circumstances a party might give for requesting a change in the time or place of the hearing include, but are not limited to, the following:

(i) The party has attempted to obtain a representative but needs additional time.

(ii) The party's representative was appointed within 10 calendar days of the scheduled hearing and needs additional time to prepare for the hearing.

(iii) The party's representative has a prior commitment to be in court or at another administrative hearing on the date scheduled for the hearing.

(iv) A witness who will testify to facts material to a party's case is unavailable to attend the scheduled hearing and the evidence cannot be otherwise obtained.

(v) Transportation is not readily available for a party to travel to the hearing.

(vi) The party is unrepresented, and is unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) that he or she has.

(h) Effect of rescheduling hearing. If a hearing is postponed at the request of the appellant for any of the above reasons, the time between the originally scheduled hearing date and the new hearing date is not counted toward the adjudication deadline specified in § 405.1016.

(i) A party's request for an in-person hearing.

(1) If a party objects to a VTC hearing or to the ALJ's offer to conduct a hearing by telephone, the party must notify the ALJ at the earliest possible opportunity before the time set for the hearing and request an in-person hearing.

(2) The party must state the reason for the objection and state the time or place he or she wants the hearing to be held.

(3) The request must be in writing.

(4) When a party's request for an in-person hearing as specified under paragraph (i)(1) of this section is granted, the ALJ must issue a decision within the adjudication timeframe specified in § 405.1016 (including any applicable extensions provided in this subpart) unless the party requesting the hearing agrees to waive such adjudication timeframe in writing.

(5) The ALJ may grant the request, with the concurrence of the Managing Field Office ALJ, upon a finding of good cause and will reschedule the hearing for a time and place when the party may appear in person before the ALJ.

§ 405.1022 Notice of a hearing before an ALJ.

(a) Issuing the notice. After the ALJ sets the time and place of the hearing, notice of the hearing will be mailed to the parties and other potential participants, as provided in § 405.1020(c) at their last known address, or given by personal service. The ALJ is not required to send a notice of hearing to a party who indicates in writing that it does not wish to receive this notice. The notice is mailed or served at least 20 calendar days before the hearing.

(b) Notice information.

(1) The notice of hearing contains a statement of the specific issues to be decided and will inform the parties that they may designate a person to represent them during the proceedings.

(2) The notice must include an explanation of the procedures for requesting a change in the time or place of the hearing, a reminder that, if the appellant fails to appear at the scheduled hearing without good cause, the ALJ may dismiss the hearing request, and other information about the scheduling and conduct of the hearing.

(3) The appellant will also be told if his or her appearance or that of any other party or witness is scheduled by VTC, telephone, or in person. If the ALJ has scheduled the appellant or other party to appear at the hearing by VTC, the notice of hearing will advise that the scheduled place for the hearing is a VTC site and explain what it means to appear at the hearing by VTC.

(4) The notice advises the appellant or other parties that if they object to appearing by VTC or telephone, and wish instead to have their hearing at a time and place where they may appear in person before the ALJ, they must follow the procedures set forth at § 405.1020(i) for notifying the ALJ of their objections and for requesting an in-person hearing.

(c) Acknowledging the notice of hearing.

(1) If the appellant, any other party to the reconsideration, or their representative does not acknowledge receipt of the notice of hearing, the ALJ hearing office attempts to contact the party for an explanation.

(2) If the party states that he or she did not receive the notice of hearing, an amended notice is sent to him or her by certified mail or e-mail, if available. (See § 405.1052 for the procedures the ALJ follows in deciding if the time or place of a scheduled hearing will be changed if a party does not respond to the notice of hearing).

§ 405.1024 Objections to the issues.

(a) If a party objects to the issues described in the notice of hearing, he or she must notify the ALJ in writing at the earliest possible opportunity before the time set for the hearing, and no later than 5 calendar days before the hearing.

(b) The party must state the reasons for his or her objections and send a copy of the objections to all other parties to the appeal.

(c) The ALJ makes a decision on the objections either in writing or at the hearing.

§ 405.1028 Prehearing case review of evidence submitted to the ALJ.

(a) Examination of any new evidence. After a hearing is requested but before it is held, the ALJ will examine any new evidence submitted with the request for hearing (or within 10 calendar days of receiving the notice of hearing) as specified in § 405.1018, by a provider, supplier, or beneficiary represented by a provider or supplier to determine whether the provider, supplier, or beneficiary represented by a provider or supplier had good cause for submitting the evidence for the first time at the ALJ level.

(b) Determining if good cause exists. An ALJ finds good cause, for example, when the new evidence is material to an issue addressed in the QIC's reconsideration and that issue was not identified as a material issue prior to the QIC's reconsideration.

(c) If good cause does not exist. If the ALJ determines that there was not good cause for submitting the evidence for the first time at the ALJ level, the ALJ must exclude the evidence from the proceeding and may not consider it in reaching a decision.

(d) Notification to all parties. As soon as possible, but no later than the start of the hearing, the ALJ must notify all parties that the evidence is excluded from the hearing.

§ 405.1030 ALJ hearing procedures.

(a) General rule. A hearing is open to the parties and to other persons the ALJ considers necessary and proper.

(b) At the hearing. At the hearing, the ALJ fully examines the issues, questions the parties and other witnesses, and may accept documents that are material to the issues consistent with § 405.1018 and § 405.1028.

(c) Missing evidence. The ALJ may also stop the hearing temporarily and continue it at a later date if he or she believes that there is material evidence missing at the hearing. If the missing evidence is in the possession of the appellant, and the appellant is a provider, supplier, or a beneficiary represented by a provider or supplier, the ALJ must determine if the appellant had good cause for not producing the evidence earlier.

(d) Good cause exists. If good cause exists, the ALJ considers the evidence in deciding the case and the adjudication period specified in § 405.1016 is tolled from the date of the hearing to the date the evidence is submitted.

(e) Good cause does not exist. If the ALJ determines that there was not good cause for not submitting the evidence sooner, the evidence is excluded.

(f) Reopen the hearing. The ALJ may also reopen the hearing at any time before he or she mails a notice of the decision in order to receive new and material evidence pursuant to § 405.986. The ALJ may decide when the evidence is presented and when the issues are discussed.

§ 405.1032 Issues before an ALJ.

(a) General rule. The issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a party's favor. (For purposes of this provision, the term “party” does not include a representative of CMS or one of its contractors that may be participating in the hearing.) However, if evidence presented before the hearing causes the ALJ to question a favorable portion of the determination, he or she notifies the parties before the hearing and may consider it an issue at the hearing.

(b) New issues–

(1) General. The ALJ may consider a new issue at the hearing if he or she notifies all of the parties about the new issue any time before the start of the hearing. The new issue may include issues resulting from the participation of CMS at the ALJ level of adjudication and from any evidence and position papers submitted by CMS for the first time to the ALJ. The ALJ or any party may raise a new issue; however, the ALJ may only consider a new issue if its resolution–

(i) Could have a material impact on the claim or claims that are the subject of the request for hearing; and

(ii) Is permissible under the rules governing reopening of determinations and decisions (see § 405.980).

(2) [Reserved]

(c) Adding claims to a pending appeal. An ALJ cannot add any claim, including one that is related to an issue that is appropriately before an ALJ, to a pending appeal unless it has been adjudicated at the lower appeals levels and all parties are notified of the new issue(s) before the start of the hearing.

§ 405.1036 Description of an ALJ hearing process.

(a) The right to appear and present evidence.

(1) Any party to a hearing has the right to appear before the ALJ to present evidence and to state his or her position. A party may appear by video-teleconferencing (VTC), telephone, or in person as determined under § 405.1020.

(2) A party may also make his or her appearance by means of a representative, who may make the appearance by VTC, telephone, or in person, as determined under § 405.1020.

(3) Witness testimony may be given and CMS participation may also be accomplished by VTC, telephone, or in person, as determined under § 405.1020.

(b) Waiver of the right to appear.

(1) A party may send the ALJ a written statement indicating that he or she does not wish to appear at the hearing.

(2) The appellant may subsequently withdraw his or her waiver at any time before the notice of the hearing decision is issued; however, by withdrawing the waiver the appellant agrees to an extension of the adjudication period as specified in § 405.1016 that may be necessary to schedule and hold the hearing.

(3) Other parties may withdraw their waiver up to the date of the scheduled hearing, if any. Even if all of the parties waive their right to appear at a hearing, the ALJ may require them to attend an oral hearing if he or she believes that a personal appearance and testimony by the appellant or any other party is necessary to decide the case.

(c) Presenting written statements and oral arguments. A party or a person designated to act as a party's representative may appear before the ALJ to state the party's case, to present a written summary of the case, or to enter written statements about the facts and law material to the case in the record. A copy of any written statements must be provided to the other parties to a hearing, if any, at the same time they are submitted to the ALJ.

(d) Waiver of adjudication period. At any time during the hearing process, the appellant may waive the adjudication deadline specified in § 405.1016 for issuing a hearing decision. The waiver may be for a specific period of time agreed upon by the ALJ and the appellant.

(e) What evidence is admissible at a hearing. The ALJ may receive evidence at the hearing even though the evidence is not admissible in court under the rules of evidence used by the court.

(f) Subpoenas.

(1) Except as provided in this section, when it is reasonably necessary for the full presentation of a case, an ALJ may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for a party to make books, records, correspondence, papers, or other documents that are material to an issue at the hearing available for inspection and copying. An ALJ may not issue a subpoena to CMS or its contractors, on his or her own initiative or at the request of a party, to compel an appearance, testimony, or the production of evidence.

(2) A party's written request for a subpoena must–

(i) Give the names of the witnesses or documents to be produced;

(ii) Describe the address or location of the witnesses or documents with sufficient detail to find them;

(iii) State the important facts that the witness or document is expected to prove; and

(iv) Indicate why these facts cannot be proven without issuing a subpoena.

(3) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the requirements set forth in paragraph (f)(2) of this section with the ALJ no later than the end of the discovery period established by the ALJ under § 405.1037(c).

(4) Where a party has requested a subpoena, a subpoena will be issued only where a party–

(i) Has sought discovery;

(ii) Has filed a motion to compel;

(iii) Has had that motion granted by the ALJ; and

(iv) Nevertheless, has not received the requested discovery.

(5) Reviewability of subpoena rulings–

(i) General rule. An ALJ ruling on a subpoena request is not subject to immediate review by the MAC. The ruling may be reviewed solely during the course of the MAC's review specified in § 405.1102, § 405.1104, or § 405.1110, as applicable. Exception. To the extent a subpoena compels disclosure of a matter for which an objection based on privilege, or other protection from disclosure such as case preparation, confidentiality, or undue burden, was made before an ALJ, the MAC may review immediately the subpoena or that portion of the subpoena as applicable.

(ii) Where CMS objects to a discovery ruling, the MAC must take review and the discovery ruling at issue is automatically stayed pending the MAC's order.

(iii) Upon notice to the ALJ that a party or non-party, as applicable, intends to seek MAC review of the subpoena, the ALJ must stay all proceedings affected by the subpoena.

(iv) The ALJ determines the length of the stay under the circumstances of a given case, but in no event is the stay less than 15 calendar days beginning after the day on which the ALJ received notice of the party or non-party's intent to seek MAC review.

(v) If the MAC grants a request for review of the subpoena, the subpoena or portion of the subpoena, as applicable, is stayed until the MAC issues a written decision that affirms, reverses, or modifies the ALJ's action on the subpoena.

(vi) If the MAC does not grant review or take own motion review within the time allotted for the stay, the stay is lifted and the ALJ's action stands.

(6) Enforcement.

(i) If the ALJ determines, whether on his or her own motion or at the request of a party, that a party or non-party subject to a subpoena issued under this section has refused to comply with the subpoena, the ALJ may request the Secretary to seek enforcement of the subpoena in accordance with section 205(e) of the Act 42 U.S.C. 405(e).

(ii) Any enforcement request by an ALJ must consist of a written notice to the Secretary describing in detail the ALJ's findings of noncompliance and his or her specific request for enforcement, and providing a copy of the subpoena and evidence of its receipt by certified mail by the party or nonparty subject to the subpoena.

(iii) The ALJ must promptly mail a copy of the notice and related documents to the party subject to the subpoena, and to any other party and affected non-party to the appeal.

(g) Witnesses at a hearing. Witnesses may appear at a hearing. They testify under oath or affirmation, unless the ALJ finds an important reason to excuse them from taking an oath or affirmation. The ALJ may ask the witnesses any questions relevant to the issues and allows the parties or their designated representatives to do so.

§ 405.1040 Prehearing and posthearing conferences.

(a) The ALJ may decide on his or her own, or at the request of any party to the hearing, to hold a prehearing or posthearing conference to facilitate the hearing or the hearing decision.

(b) The ALJ informs the parties of the time, place, and purpose of the conference at least 7 calendar days before the conference date, unless a party indicates in writing that it does not wish to receive a written notice of the conference.

(c) At the conference, the ALJ may consider matters in addition to those stated in the notice of hearing, if the parties consent in writing. A record of the conference is made.

(d) The ALJ issues an order stating all agreements and actions resulting from the conference. If the parties do not object, the agreements and actions become part of the hearing record and are binding on all parties.

§ 405.1042 The administrative record.

(a) Creating the record.

(1) The ALJ makes a complete record of the evidence, including the hearing proceedings, if any.

(2) The record will include marked as exhibits, the documents used in making the decision under review, including, but not limited to, claims, medical records, written statements, certificates, reports, affidavits, and any other evidence the ALJ admits. In the record, the ALJ must also discuss any evidence excluded under § 405.1028 and include a justification for excluding the evidence.

(3) A party may review the record at the hearing, or, if a hearing is not held, at any time before the ALJ's notice of decision is issued.

(4) If a request for review is filed or the case is escalated to the MAC, the complete record, including any recording of the hearing, is forwarded to the MAC.

(5) A typed transcription of the hearing is prepared if a party seeks judicial review of the case in a Federal district court within the stated time period and all other jurisdictional criteria are met, unless, upon the Secretary's motion prior to the filing of an answer, the court remands the case.

(b) Requesting and receiving copies of the record.

(1) A party may request and receive a copy of all or part of the record, including the exhibits list, documentary evidence, and a copy of the tape of the oral proceedings. The party may be asked to pay the costs of providing these items.

(2) If a party requests all or part of the record from the ALJ and an opportunity to comment on the record, the time beginning with the ALJ's receipt of the request through the expiration of the time granted for the party's response does not count toward the 90 calendar day adjudication deadline.

§ 405.1044 Consolidated hearing before an ALJ.

(a) A consolidated hearing may be held if one or more of the issues to be considered at the hearing are the same issues that are involved in another request for hearing or hearings pending before the same ALJ.

(b) It is within the discretion of the ALJ to grant or deny an appellant's request for consolidation. In considering an

appellant's request, the ALJ may consider factors such as whether the claims at issue may be more efficiently decided if the requests for hearing are combined. In considering the appellant's request for consolidation, the ALJ must take into account the adjudication deadlines for each case and may require an appellant to waive the adjudication deadline associated with one or more cases if consolidation otherwise prevents the ALJ from deciding all of the appeals at issue within their respective deadlines.

(c) The ALJ may also propose on his or her own motion to consolidate two or more cases in one hearing for administrative efficiency, but may not require an appellant to waive the adjudication deadline for any of the consolidated cases.

(d) Before consolidating a hearing, the ALJ must notify CMS of his or her intention to do so, and CMS may then elect to participate in the consolidated hearing, as a party, by sending written notice to the ALJ within 10 calendar days after receipt of the ALJ's notice of the consolidation.

(e) If the ALJ decides to hold a consolidated hearing, he or she may make either a consolidated decision and record or a separate decision and record on each claim. The ALJ ensures that any evidence that is common to all claims and material to the common issue to be decided is included in the consolidated record or each individual record, as applicable.

§ 405.1046 Notice of an ALJ decision.

(a) General rule. Unless the ALJ dismisses the hearing, the ALJ will issue a written decision that gives the findings of fact, conclusions of law, and the reasons for the decision. The decision must be based on evidence offered at the hearing or otherwise admitted into the record. The ALJ mails a copy of the decision to all the parties at their last known address, to the QIC that issued the reconsideration determination, and to the contractor that issued the initial determination. For overpayment cases involving multiple beneficiaries, where there is no beneficiary liability, the ALJ may choose to send written notice only to the appellant. In the event a payment will be made to a provider or supplier in conjunction with this ALJ decision, the contractor must also issue a revised electronic or paper remittance advice to that provider or supplier.

(b) Content of the notice. The decision must be written in a manner calculated to be understood by a beneficiary and must include–

(1) The specific reasons for the determination, including, to the extent appropriate, a summary of any clinical or scientific evidence used in making the determination;

(2) The procedures for obtaining additional information concerning the decision; and

(3) Notification of the right to appeal the decision to the MAC, including instructions on how to initiate an appeal under this section.

(c) Limitation on decision. When the amount of payment for an item or service is an issue before the ALJ, the ALJ may make a finding as to the amount of payment due. If the ALJ makes a finding concerning payment when the amount of payment was not an issue before the ALJ, the contractor may independently determine the payment amount. In either of the aforementioned situations, an ALJ's decision is not binding on the contractor for purposes of determining the amount of payment due. The amount of payment determined by the contractor in effectuating the ALJ's decision is a new initial determination under § 405.924.

(d) Timing of decision. The ALJ issues a decision by the end of the 90 calendar day period beginning on the date when the request for hearing is received by the entity specified in the QIC's reconsideration, unless the 90 calendar day period is extended as provided in § 405.1016.

(e) Recommended decision. An ALJ issues a recommended decision if he or she is directed to do so in the MAC's remand order. An ALJ may not issue a recommended decision on his or her own motion. The ALJ mails a copy of the

recommended decision to all the parties at their last known address.

§ 405.1048 The effect of an ALJ's decision.

The decision of the ALJ is binding on all parties to the hearing unless–

(a) A party to the hearing requests a review of the decision by the MAC within the stated time period or the MAC reviews the decision issued by an ALJ under the procedures set forth in § 405.1110, and the MAC issues a final decision or remand order or the appeal is escalated to Federal district court under the provisions at § 405.1132 and the Federal district court issues a decision.

(b) The decision is reopened and revised by an ALJ or the MAC under the procedures explained in § 405.980;

(c) The expedited access to judicial review process at § 405.990 is used;

(d) The ALJ's decision is a recommended decision directed to the MAC and the MAC issues a decision; or

(e) In a case remanded by a Federal district court, the MAC assumes jurisdiction under the procedures in § 405.1138 and the MAC issues a decision.

§ 405.1052 Dismissal of a request for a hearing before an ALJ.

Dismissal of a request for a hearing is in accordance with the following:

(a) An ALJ dismisses a request for a hearing under any of the following conditions:

(1) At any time before notice of the hearing decision is mailed, if only one party requested the hearing and that party asks to withdraw the request. This request may be submitted in writing to the ALJ or made orally at the hearing. The request for withdrawal must include a clear statement that the appellant is withdrawing the request for hearing and does not intend to further proceed with the appeal. If an attorney or other legal professional on behalf of a beneficiary or other appellant files the request for withdrawal, the ALJ may presume that the representative has advised the appellant of the consequences of the withdrawal and dismissal.

(2) Neither the party that requested the hearing nor the party's representative appears at the time and place set for the hearing, if–

(i) The party was notified before the time set for the hearing that the request for hearing might be dismissed without further notice for failure to appear;

(ii) The party did not appear at the time and place of hearing and does not contact the ALJ hearing office within 10 calendar days and provide good cause for not appearing; or

(iii) The ALJ sends a notice to the party asking why the party did not appear; and the party does not respond to the ALJ's notice within 10 calendar days or does not provide good cause for the failure to appear.

(iv) In determining whether good cause exists under this paragraph (a)(2), the ALJ considers any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language), that the party may have.

(3) The person or entity requesting a hearing has no right to it under § 405.1002.

(4) The party did not request a hearing within the stated time period and the ALJ has not found good cause for extending the deadline, as provided in § 405.1014(c).

(5) The beneficiary whose claim is being appealed died while the request for hearing is pending and all of the following criteria apply:

(i) The request for hearing was filed by the beneficiary or the beneficiary's representative, and the beneficiary's surviving spouse or estate has no remaining financial interest in the case. In deciding this issue, the ALJ considers if the surviving spouse or estate remains liable for the services that were denied or a Medicare contractor held the beneficiary liable for subsequent similar services under the limitation of liability provisions based on the denial of the services at issue.

(ii) No other individuals or entities that have a financial interest in the case wish to pursue an appeal under § 405.1002.

(iii) No other individual or entity filed a valid and timely request for an ALJ hearing in accordance to § 405.1014.

(6) The ALJ dismisses a hearing request entirely or refuses to consider any one or more of the issues because a QIC, an ALJ or the MAC has made a previous determination or decision under this subpart about the appellant's rights on the same facts and on the same issue(s) or claim(s), and this previous determination or decision has become binding by either administrative or judicial action.

(7) The appellant abandons the request for hearing. An ALJ may conclude that an appellant has abandoned a request for hearing when the ALJ hearing office attempts to schedule a hearing and is unable to contact the appellant after making reasonable efforts to do so.

(b) Notice of dismissal. The ALJ mails a written notice of the dismissal of the hearing request to all parties at their last known address. The notice states that there is a right to request that the MAC vacate the dismissal action.

You can access these regulations at various websites, including: www.law.cornell.edu**.**

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[1] Medicare Benefit Policy Manual, Publ. 100-2, Ch. 1, § 10, which can be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.
[2] Medicare Benefits Policy Manual, Pub. 100-02, Chapter 6, § 20.6, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.