Chapter 3 PROCEDURAL SCREENING

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II-3-1 Procedural Screening, Generally

An initial screening of the case file and request for hearing must be conducted to determine whether:

- The request for hearing involves an appealable decision (see II-3-2, Appealable Decision);
- The individual or entity filing the request for hearing has standing to appeal (see II-3-3, Standing);
- The amount in controversy threshold is met (see II-3-4, Amount in Controversy);
- The request for hearing is timely filed (see II-3-5, Timely Request for Hearing);
- The request for hearing is complete and all parties were copied on the request (see II-3-6, Complete Request for Hearing and Copy Requirement).

II-3-2 Appealable Decision

A. Jurisdiction

When reviewing a request for hearing, there must be an appealable action.

An ALJ has jurisdiction over certain actions involving appeals of Part A and Part B claims determinations, including:

- QIC reconsideration.
- QIC dismissal of a request for reconsideration.
- Request for a reconsideration by a QIC that is escalated to OMHA.
- Reconsiderations of QIO determinations involving:
  - Determination of the medical necessity of services or reasonableness or appropriateness of placement of an individual at an acute level of patient care.
  - Determination on the termination of services; or
  - Determination on the discharge of an individual.

An ALJ does not have jurisdiction over certain actions, including:

- Actions that are not initial determinations under § 405.926.
- QIC dismissal of a request for reconsideration of a Medicare Administrative Contractor's dismissal of a redetermination request. § 405.972(e).
- QIC reconsideration of a Medicare Administrative Contractor's dismissal of a redetermination request. § 405.974(b)(3).
- Part 426 determination regarding the validity of a Medicare contractor Local Coverage Determination or a Medicare National Coverage Determination. §§ 405.1060(b), 405.1062(c).
- A decision not to reopen a reconsideration or redetermination. § 405.980(a)(5).
- Part 498 determination on a provider/supplier's billing privileges in the Medicare program (for example, enrollment denials and revocations).

  NOTE: Claim denials resulting from revocations are appealable under Part 405, Subpart I.
- QIO Diagnosis Related Group (DRG) validation. § 478.15©.
- QIO quality of care determination, whether QIO-initiated review of the quality of care or QIO determination in response to a beneficiary complaint). § 478.40.

B. If No Appealable Action

If there is no appealable action, the request for hearing is dismissed for no right to a hearing.

II-3-3 Standing

Citations: §§ 1155 and § 1869 of the Act; §§ 405.906, 478.40.

A. Part A/B QIC Reconsideration

Any party may request a hearing.

Exception. The only party that may request escalation is the party that filed a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the adjudication period.

Party status and standing to appeal are not contingent upon financial liability for the claim unless clearly stated in the regulations (for example, if the beneficiary is deceased and there is no estate, any person obligated to make or entitled to receive payment in accordance with Part 424, Subpart E may invoke party status under § 405.906(a); thus, the individual must demonstrate a financial interest in the claim).

Parties who may request a hearing include (§ 405.906(a)–(c)):

1. Parties based on beneficiary's party status.

- 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.
- Deceased beneficiary's estate.
- If the beneficiary is deceased, and there is no estate, any party obligated to make or entitled to receive payment in accordance with Part 424, Subpart E.

  NOTE: Payment by a third party payer does not entitle an individual or entity to party status.
- Provider or supplier that was not already a party to the initial determination and has received an assignment of appeal rights from the beneficiary in accordance with § 405.912 (form CMS-20031 must be used).

  NOTE: A physician or other supplier that has accepted assignment of a claim is already a party to the claim and has separate appeal rights. An assignment of appeal rights cannot be executed because the physician or other supplier is already a party.
- Provider or supplier that is not already a party and that furnished services to a beneficiary who subsequently died, when there is no other party available to appeal the determination.

2. **Parties based on the provider's or supplier's party status.**

   - Medicare provider that files a claim, or supplier that accepts assignment, for items or services furnished to a beneficiary.
   - A non-participating physician (supplier) who has not taken assignment of the claim, if the physician may be liable to refund monies collected for services furnished to the beneficiary because those services were denied as not reasonable and necessary on the basis of § 1862(a)(1) of the Act.
   - A non-participating supplier of medical equipment or supplies that has not taken assignment, if the supplier may be liable to refund the amount collected, in accordance with §§ 1834(a)(18) and 1834(j)(4) of the Act, because there was no advance notice the supplier did not have a supplier number or the denied item was: (1) furnished after an unsolicited contact; (2) included in the list of items requiring an advance determination of coverage under § 1834(a)(15) of the Act; or (3) not reasonable and necessary.

3. **Medicaid State Agencies.**

   - Medicaid State Agency that (1) filed a timely request for a redetermination and (2) made payment or may be liable for payment for (3) items or services furnished to an individual enrolled in both the Medicare and Medicaid programs.

B. Part A/B QIO Reconsideration

1. Under § 1155 of the Act, a beneficiary, provider, or practitioner may request a reconsideration from the QIO. However, only a beneficiary may request a hearing by an ALJ to review a QIO reconsideration of a QIO determination made under title XI or XVIII when § 1869 of the Act does not apply. § 1155 of the Act; § 478.40; CMS, *Quality Improvement Organizations Manual*, Pub. 100-10 (QIOM), Ch. 7, § 7500 (QIOM, Ch. 7, § 7500).
2. If a QIO determination is an initial determination under § 1869 of the Act (that is, it is an initial determination made under § 1154(a)(2) of the Act), a beneficiary, a provider, or a supplier may request a hearing by an ALJ of a reconsideration of the QIO determination.

C. If No Party with Standing

If there is no party with standing, the request for hearing is dismissed for no right to a hearing.

II-3-4 Amount in Controversy

Citations: § 1869(b)(1)(E) of the Act; §§ 405.1002(b)(3), 405.1006(b).

A. Generally

A party is entitled to a hearing only if the amount in controversy (AIC) threshold is met.

The minimum AIC is revised annually based on a formula prescribed by Congress:

Calendar Year	Minimum AIC	Federal Register Publication
2017	$160	81 Fed. Reg. 65651 (Sep. 23, 2016)
2016	$150	80 Fed. Reg. 57827 (Sep. 25, 2015)
2015	$150	79 Fed. Reg. 57933 (Sep. 26, 2014)
2014	$140	78 Fed. Reg. 59702 (Sep. 27, 2013)
2013	$140	77 Fed. Reg. 59618 (Sep. 28, 2012)
2012	$130	76 Fed. Reg. 59138 (Sep. 23, 2011)
2011	$130	75 Fed. Reg. 58407 (Sep. 24, 2010)
2010	$130	74 Fed. Reg. 48976 (Sep. 25, 2009)
2009	$120	73 Fed. Reg. 55847 (Sep. 26, 2008)
2008	$120	72 Fed. Reg. 73348 (Dec. 27, 2007)
2007	$110	71 Fed. Reg. 75250 (Dec. 14, 2006)
2006	$110	71 Fed. Reg. 2247 (Jan. 13, 2006)
2005	$100	70 Fed. Reg. 11420, 11423 (Mar. 8, 2005)
2004	$100	67 Fed. Reg. 62478, 62480 (Oct. 7, 2002)

NOTE: For an appeal of a QIO reconsideration, the regulation at § 478.40 specifies a $200 AIC threshold. CMS Ruling 02-01 aligned the minimum AIC threshold for appeals from a QIO reconsideration with the threshold established by BIPA ($100) for QIO determinations specified in § 521 of BIPA. *See* 67 Fed. Reg. 62478, 62480 (Oct. 7, 2002). This AIC threshold was subsequently amended by the MMA to adjust annually. As indicated in subsequent rulemaking, the statute and regulations govern the AIC threshold for ALJ hearings, despite any direct inconsistencies with § 478.40. *See* 69 Fed. Reg. 69251, 69260 (Nov. 26, 2004).

B. Determination of Appropriate Calendar Year for Minimum AIC

The date OMHA receives a request for hearing determines the minimum AIC to be used.

Example: If a request for hearing is sent on December 30, 2012, and received by OMHA on January 2, 2013, the AIC for calendar year 2013 applies to the request.

C. When to Calculate AIC

The exact AIC must be calculated if the record does not clearly establish whether the minimum AIC is met for the claim(s) at issue.

D. How to Calculate AIC

For disputes involving claims for items or services, the AIC is calculated as follows (§ 405.1006(d)):

Step One. Find the actual amount charged to the individual (for example, if the amount charged is $200 but Medicare would only allow $100 if the service was approved, $200 is used to calculate the AIC).

- For purposes of calculating the AIC, if payment is made under § 1879 of the Act (under the rules prescribed at § 411.400) for the disputed items or services, the AIC is the amount the beneficiary would have been charged if the payment had not been made.
- For purposes of calculating the AIC, if the beneficiary's liability for the items or services is limited under § 1879 of the Act (under the rules prescribed at § 411.402), the AIC is the amount the beneficiary would have been charged if the liability had not been limited.

Step Two. Subtract any Medicare payments already made or awarded on the claim (for example, the amount paid for a lower, allowed level of service; or portions of the claim that were covered, such as some but not all components of a DME item).

Step Three. Subtract any deductible or coinsurance amounts applicable to the claim (for example, the 20% co-insurance on the allowable Medicare amount that is generally required for certain Part B claims).

E. Calculation of AIC in Specific Situations

1. Statistical samples.

For cases involving overpayment assessments determined by extrapolating from a sample, the AIC is:

a. The extrapolated amount of any disputed claim(s) in the sample, if the sampling methodology is not also disputed; or

b. The entire extrapolated amount, if the sampling methodology (and therefore the resulting extrapolation) is disputed.

2. Termination of services.

For cases involving a termination of services (for example, an appeal from a QIC's reconsideration affirming a QIO's expedited determination regarding a provider discontinuing Medicare covered services), the AIC is calculated using the charges for services furnished after the disputed termination of Medicare covered services, or if

continued services were not furnished to the beneficiary, the estimated amount that would have been charged if the services had been furnished.

3. Medicare Secondary Payer (MSP).

For cases involving MSP recovery actions, the AIC is the MSP demand amount. When a Medicare recovery is made as the result of a beneficiary obtaining a settlement, judgment, award, or other payment of a disputed claim, the MSP demand amount is generally the amount of the conditional payments asserted by Medicare reduced by costs incurred by the beneficiary in the process of obtaining that settlement, judgment, award, or other payment. *See* § 411.37.

F. Aggregation to Meet the Minimum AIC

1. Generally.

Claims may be considered together (aggregated) to meet the minimum AIC, when any of the claims involved in the request for aggregation do not individually meet the AIC. The claims may be a combination of Part A and Part B claims. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the minimum AIC.

NOTE: Aggregation is only used to meet the minimum AIC. Aggregation is not a mechanism to request consideration of multiple claims together for a party's convenience or administrative efficiency.

2. Aggregation Request with Previously Filed Requests for Hearing.

a. QIC reconsiderations.

An appellant's request seeking to aggregate claims with claims specified in an appellant's previously filed request is not permitted.

i. If a new request for hearing includes claims that individually meet the AIC threshold, the request will be processed separately as a regular request for hearing, and the request for aggregation disregarded.

ii. If a new request for hearing includes claims that together meet the AIC threshold, the request will be processed separately as a potential aggregation.

iii. If a new request for hearing includes claims that individually or together do not meet the AIC threshold, the request will be dismissed for failing to meet the minimum AIC.

b. Escalations from the QIC.

For appeals that are escalated from the QIC level to OMHA, any claims that the appellant seeks to aggregate must be listed in the same request for escalation. An

appellant may not aggregate the escalated claims with a previously filed escalation request or request for hearing. § 405.1006(e)(2)(ii).

G. Reviewing a Request for Aggregation

1. The ALJ must review a request for aggregation, and determine whether the following requirements have been met:

   a. Request for aggregation of non-escalated claims. § 405.1006(e)(1) and (f).

   i. Request for hearing lists all the claims to be aggregated, which must have been previously reconsidered, and states why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services.

   NOTE: A request does not have to use the term "aggregate" or specifically mention meeting the AIC requirement.

   Example. If a single request filed by a supplier lists all of the claims and explains the claims involve similar items provided to multiple beneficiaries, the requirements for requesting aggregation are fulfilled. However, the ALJ determines whether the services were similar under the applicable legal standard.

   ii. Request for hearing was filed within 60 calendar days after receipt of all of the reconsiderations being appealed.

   iii. Claims involve the delivery of similar or related services (if single appellant requesting) or involve common issues of law and fact (if multiple appellants).

   - "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. § 405.1006(a)(1).
   - "Delivery of similar or related services" means like or coordinated services or items provided to one or more beneficiaries. § 405.1006(a)(2).

   b. Request for aggregation of escalated claims. § 405.1006(e)–(f).

   i. Lists all the claims to be aggregated in the same request for escalation, and states why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services;

   ii. Concerns claims that were pending before the QIC in conjunction with the same request for reconsideration; and

iii. Claims involve the delivery of similar or related services (if requested by a single appellant) or involve common issues of law and fact (if requested by multiple appellants).

- "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. § 405.1006(a)(1).
- "Delivery of similar or related services" means like or coordinated services or items provided to one or more beneficiaries. § 405.1006(a)(2).

2. If the ALJ determines the requirements for aggregation are met, and the minimum AIC is satisfied, staff continues processing the case. The granting of the request for aggregation must be explicitly stated in the decision.
3. If the ALJ determines the requirements for aggregation have not been met and denies the request for aggregation, resulting in insufficient AIC, see the instructions in subsection **H**, below.

H. Addressing Insufficient AIC

1. Special procedures for appeals of QIO reconsiderations.

For QIO reconsiderations where the ALJ determines the AIC threshold is not met, the ALJ must notify the parties and allow 15 calendar days from receipt of the notice for the parties to submit additional evidence to demonstrate the AIC threshold is met. § 478.44(b).

2. If the minimum AIC is not met, the request for hearing is dismissed for no right to a hearing.
   - If the minimum AIC is not met because the request for aggregation is invalid, the reason must be included in the dismissal.

NOTE: Unless otherwise indicated, the Part 405 citations above are made applicable to QIO reconsiderations pursuant to § 478.40(c).

II-3-5 Timely Request for Hearing

Citations: §§ 405.942, 405.1002, 405.1014.

A. When the Request for Hearing Must be Filed

1. An appellant must file a request for hearing within 60 calendar days after receiving the notice of reconsideration. § 405.1014(b).
2. The request for hearing is considered filed on the date when it is received by the entity specified in the reconsideration (but see subsection **B,** below). § 405.1002(a)(4).
3. When the last day for filing a request for hearing falls on a weekend, Federal holiday, or any other day that the receiving OMHA office is closed for business (for example, due to weather), the time frame for filing is automatically extended to the next business day that the OMHA office is open for business.
4. An appellant is presumed to have received the reconsideration notice 5 calendar days after the date of the notice, unless the record contains evidence to the contrary. § 405.1002(a)(3).

   NOTE: If the appellant introduces evidence that the reconsideration was not received within the 5-day mailing presumption, thereby making the request for hearing timely filed, this is not a good cause determination. Rather, it is an issue that affects when the time period to request a hearing began.

   Example. The QIC issues a reconsideration notice on Tuesday, September 23, 2014. The record does not show the date the appellant actually received it, so the 5-calendar day regulatory presumption applies and the 60-calendar day time period for filing the request for hearing begins on Sunday, September 28, 2014. Applying the 60-calendar day period for timely filing, the request for hearing should be filed no later than November 27, 2014. However, November 27, 2014, is a Federal holiday, so the time frame is automatically extended to the next business day that the OMHA office is open for business, on Friday, November 28, 2014.

B. Where the Request for Hearing Must be Filed

1. An appellant must file a request for hearing with the entity specified in the QIC's notice of reconsideration. However, if a request for hearing is received by an entity other than the entity specified in the notice of reconsideration (for example, an incorrect OMHA entity or an entity outside OMHA, such as SSA or CMS), the date that the incorrect entity received the request must be used to determine timeliness.

Example. Using the example in paragraph A, the QIC's reconsideration notice identified OMHA Central Operations as the entity where appeals should be filed. If the OMHA Miami Field Office received the request on Friday, November 28, 2014, the Miami Field Office date stamps the request for hearing as received on that date and forwards it to OMHA Central Operations for further processing. However, the November 28, 2014, received date will be used to assess the timeliness of the request, regardless of when OMHA Central Operations receives the request.

2. If the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the adjudication period begins on the date the entity specified in the QIC's reconsideration receives the request for hearing. § 405.1014(b)(2). In this situation, OMHA Central Operations issues an acknowledgement letter that notifies the appellant of the date of receipt of the request, and the start of the adjudication period.

C. Requesting an Extension of Time

Any appellant who has a right to a hearing but does not file a timely request may ask for an extension of time to make the request. The request for an extension must be in writing (form HHS-727 may be used, but is not required), must give the reasons why the request was not filed within the required time period, and be filed with the entity specified in the notice of reconsideration. § 405.1014(c).

NOTE: Any explanation for a late filing is deemed a request for an extension of time to request a hearing.

D. Addressing Untimely Requests

1. Considerations when evaluating good cause. § 405.942(b)(2)–(3).

When evaluating whether an appellant has shown good cause for missing a deadline to request a hearing, an ALJ considers:

- The circumstances that kept the party from making the request on time;
- If the contractor's or OMHA's action(s) misled the party; and
- 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.

An ALJ must evaluate whether an appellant has shown good cause based on the circumstances of the case. Examples of when good cause for late filing may be found to exist include, but are not limited to, the following circumstances:

- The party was prevented by serious illness from contacting OMHA in person, in writing, or through a friend, relative, or other person;
- The party had a death or serious illness in his or her immediate family;
- Important records of the party were destroyed or damaged by fire or other accidental cause;
- The contractor gave the party incorrect or incomplete information about when and how to request a hearing;
- The party did not receive notice of the reconsideration; or
- The party sent the request to a Government agency in good faith within the time limit, and the request did not reach the appropriate entity until after the time period to file a request expired.

2. Developing good cause.

If there is no evidence in the file indicating that the appellant has provided a reason for the late filing, an interim letter requesting the appellant show cause for the late filing (OMHA-110 Interim Letter, available in MATS) must be sent in the following circumstances:

- The appellant is an unrepresented beneficiary;
- The appellant is a beneficiary not represented by a provider or supplier; or
- There is evidence in the record indicating notice would be appropriate given the circumstances of the case.

  Example 1. A request for extension is submitted, but no reason is given.

  Example 2. An appellant is involved in post-reconsideration discussions with the QIC, and was waiting to file the request until the issue with the reconsideration was resolved.

The notice provides 60 calendar days from the date of the interim letter for an appellant to provide a reason for the late filing. The original interim letter must be placed in the file, and a copy sent to the appellant.

3. **Good cause is found.**

   If a request for hearing is untimely, but the ALJ determines that the appellant established good cause for missing the filing deadline, the ALJ grants an extension for filing the request for hearing.

   NOTE: The adjudication period begins on the date the ALJ grants the request to extend the filing deadline, which must be explicitly stated in the decision.

4. **Good cause is not found.**

   If a request for hearing is untimely and there is no good cause for extending the filing deadline, the request is dismissed.

   a. If the appellant did not provide a reason for the untimely filing, the dismissal will include a summary statement relating this fact (for example, "The appellant has not provided any explanation for its late filing; thus, I find that there is no good cause to extend the period for timely filing in this case.")

   b. If the appellant provided a reason for the untimely filing, the dismissal must explain why the reason does not constitute good cause.

NOTE: Unless otherwise indicated, the Part 405 citations above are made applicable to QIO reconsiderations reviewable under § 1155 of the Act pursuant to § 478.40(c).

II-3-6 Complete Request for Hearing and Copy Requirement

Citations: § 405.1014.

A. Generally

1. The request for hearing must be in writing, but may be in any format that contains all required information.
    - Use of form CMS-20034 A/B is recommended for appeals of QIC reconsiderations, but is not mandatory.
2. Although OMHA does not encourage submission of a request for hearing via fax, filing by fax is acceptable.
3. Whether a request for hearing meets the content requirements for a hearing request will be determined by taking into consideration all of the information submitted with the request.

    Example. An appellant submits a request for hearing that attaches a QIC reconsideration. The hearing request is considered complete if these documents together contain all of the content information required for a request for hearing.

B. Required Elements for a Complete Request for Hearing

The request for hearing must be reviewed to determine whether the request includes the required elements (§ 405.1014(a)):

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

    NOTE: If a request for hearing references a Medicare Appeal Number for a QIC reconsideration corresponding with multiple claims and/or beneficiaries, but the request for hearing only specifically includes some of the claims/beneficiaries in the reconsideration, the request for hearing is treated as a request for hearing on only the listed claims/beneficiaries. However, if the request for hearing is not clear on its face, the appellant must be contacted for clarification.
2. If the beneficiary is not the appellant, the name and address of the appellant.
3. If a representative is involved, the name and address of the designated representative.
    - If a representative is listed on the request for hearing, staff must confirm there is a valid appointment of representative or evidence of an authorized representative.
4. The document control or appeal number assigned by the QIC, if applicable.

- This is the "Medicare Appeal Number" located on the first page of the reconsideration.

NOTE: There is no document control number for QIO appeals.

5. The dates of service for the claim(s) at issue.
6. The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed.

   NOTE: This does not require a detailed explanation. Any reason for disagreement satisfies the requirement (for example, "I disagree with the reconsideration because the services were medically necessary").

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

   NOTE: If no evidence is submitted, it is not necessary for an appellant to include a statement, and the appellant may not be required to provide this information. Further, failure to indicate in the request for hearing that additional evidence will be submitted does not preclude the evidence from being submitted at a later date, in accordance with the regulations (for example, in response to the notice of hearing).

C. Copy Requirement

1. The appellant must send a copy of the request for hearing to the other parties to the appeal who were sent copies of the reconsideration being appealed. § 405.1014(b).

   Example 1. Where a provider or supplier is the appellant, the beneficiary is generally a party and copied on the request for hearing.

   Example 2. Where a Medicaid State Agency (for example, the Commonwealth of Massachusetts) is the appellant, the beneficiary and provider are parties and copied on the request for hearing.

   NOTE: CMS contractors are not parties, even if copied on the reconsideration.

2. A request for hearing must be reviewed to ensure that all parties who were sent copies of the reconsideration being appealed were sent copies of the appellant's request for hearing.

   a. At a minimum, any of the following is sufficient to meet the requirement to copy the other parties:

      i. Checking the box on form CMS-20034 A/B, Requests for Medicare Hearing by an Administrative Law Judge (ALJ), indicating the other parties were copied;

ii. A written appellant statement, submitted with the request for hearing, that a copy of the request for hearing was sent to the other parties;

iii. A request for hearing in letter format that identifies the other parties were copied, such as on a "cc:" line.

NOTE: Evidence of proof of delivery (in other words, receipt by the other party) is not required.

b. An appellant may provide additional evidence of sending a copy of the request for hearing to the other parties, but it is not required unless there is an indication in the record that the parties were not actually copied.

NOTE: The appellant is not required to send a copy of all of the evidence submitted with the request for hearing to the other parties. Where an appellant submits extensive information with the request for hearing, such as a brief or other evidence, it is sufficient for the appellant to provide the other parties with the request for hearing and indicate the other documentation is available upon request, providing the relevant contact information.

D. Addressing Incomplete Requests for Hearing and Failure to Copy

If the request for hearing is incomplete or the record does not contain evidence that the appellant copied the other parties who were sent a copy of the reconsideration being appealed, the appellant must be given an opportunity to cure the defects to perfect the request for hearing.

E. Providing the Opportunity to Cure

Staff must take the following steps:

1. Issue an interim letter (OMHA-110 Interim Letter, available in MATS) to the appellant:
   a. Notifying the appellant;
      i. The request is incomplete; and/or
      ii. The appellant failed to provide sufficient evidence that the other parties who were copied on the reconsideration being appealed were sent a copy of the request for an ALJ hearing.
   b. Specifying the information that must be provided to complete the request;
      i. If information is missing from the request for hearing, the appellant must provide the information detailed in the letter.

ii. If the appellant failed to provide sufficient evidence that the other parties were sent a copy of the request for hearing, the appellant must provide the required evidence, which is a statement or documentation indicating: (1) that the appellant sent a copy of the request for an ALJ hearing to the other parties who were sent a copy of the reconsideration being appealed; (2) the names and addresses of the other parties who were sent a copy of the request for ALJ hearing; and (3) the date the appellant sent the copy of the request for ALJ hearing to the other parties.

c. Providing 60 calendar days from the date of the letter for the appellant to provide the specified information;

NOTE: The letter must be mailed on the date stated on the interim letter.

d. Notifying the appellant that the request for hearing may be dismissed if the information is not provided within the specified time period; and

e. Informing the appellant;

i. Where information is missing from the request for hearing, the date of receipt of the initial request protects the filing date, and the adjudication period will only begin upon receipt of the missing information; and/or

ii. Where the appellant failed to copy the other parties, the adjudication period will be tolled until all parties to the QIC reconsideration receive notice of the request for hearing.

Exception. Where the party requesting the hearing is an unrepresented beneficiary, OMHA staff will send a letter to the other parties who were sent a copy of the reconsideration being appealed, informing the other parties that the beneficiary has submitted a request for hearing.

2. Upon receipt, review the information submitted by the appellant and determine whether it satisfies the information detailed in the interim letter.

a. Defects cured.

- If the appellant provides the information missing from the request for hearing within the 60-calendar day period, the adjudication period begins on the date the information provided completes the request for hearing.
- If the appellant furnishes sufficient evidence that the other parties who were copied on the reconsideration being appealed were sent a copy of the request for an ALJ hearing within the 60-calendar day period, the adjudication period is tolled from initial receipt of the request for hearing until receipt of the evidence.

b. Defects not cured.

- If the appellant does not cure the defects, the request for hearing is dismissed for no right to a hearing.

NOTE: Unless otherwise indicated, the Part 405 citations above are made applicable to QIO reconsiderations reviewable under § 1155 of the Act pursuant to § 478.40(c).