

OMHA Case Processing Manual

Chapter 11 PROCEDURAL REVIEW AND DETERMINATIONS

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11.0 Chapter overview

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The procedural review is required to ensure that a request for hearing or review of dismissal meets jurisdictional and filing requirements, and that procedural determinations are made before case development occurs, or a conference or hearing is scheduled (*see* [OCPM 14.2.1](#)). If there is a procedural defect, the defect may result in a dismissal or may require an opportunity for the appellant to resolve the defect. If an adjudication time frame applies to the case, a procedural defect may delay the start of, or extend, the adjudication time frame. When the procedural review is complete, and any identified defects have been resolved, and any applicable determinations have been made, the case moves forward in the adjudication process. Specialized procedural review is required for requests for **expedited** hearings in Part D appeals; however, a hearing may be scheduled before the screening is complete and any procedural defects are resolved, to facilitate meeting the 10 calendar day adjudication period (*see* [OCPM 14.2.1](#)).

Caution: When taking the actions described in this chapter, ensure that all PII, PHI, and Federal Tax Information is secured and only disclosed to authorized individuals (internally, those who need to know).

11.1 Appealable actions and escalations

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OMHA adjudicators have statutory jurisdiction, delegated from the Secretary, over matters specified in regulation. If there is no right to request a hearing, a review of a dismissal, or an escalation to OMHA, the request must be dismissed (see [OCPM 17.1.5.1](#)).

Note: If an appeal involves an unusual matter or a type of determination you do not recognize, check the appeal instructions that the prior adjudicating entity provided to the party. If the instructions do not indicate a request for hearing or review can be filed with OMHA, consult a senior or supervisory attorney in your office.

11.1.1 Which actions are appealable to OMHA?

The following actions are appealable to OMHA:

- **Part A** or **Part B** QIC reconsiderations involving an initial determination.¹
- **Part C** IRE reconsiderations involving an organization determination.²
- **Part D** IRE reconsiderations involving a coverage determination or at-risk determination.³
- **QIO** reconsidered determinations under **Part A**, **Part B**, or **Part C** involving:
 - Determinations on the medical necessity of services, or reasonableness or appropriateness of placement of an individual at an acute level of patient care;
 - Determinations on the termination of services; or
 - Determinations on the discharge of an individual.⁴
- **SSA** reconsiderations involving an initial determination of:
 - An individual's eligibility or entitlement to receive Medicare benefits;⁵

¹ 42 C.F.R. § 405.1002; see also § 405.924 (describing initial determinations)

² 42 C.F.R. § 422.600; see also § 422.566 (describing organization determinations).

³ 42 C.F.R. § 423.2002; see also § 423.566 (describing coverage determinations).

⁴ 42 C.F.R. § 478.40(b); see also § 405.924(b)(10), (c).

⁵ 42 C.F.R. § 405.904(a)(1).

- A Medicare **Part B** late enrollment penalty; or⁶

Caution: Reconsiderations of **Part D** late enrollment penalties are not appealable to OMHA.⁷

- A **Part B** (and if enrolled in a Prescription Drug Plan, **Part D**) IRMAA.⁸
- **Dismissals** of requests for reconsideration issued by a **QIC**, **IRE**, or **QIO**.⁹

11.1.2 What are some examples of actions that are not appealable to OMHA?

Examples of actions that are not appealable to OMHA include:

- QIC or IRE **determinations on requests for review of a dismissal** of a request for redetermination or MAO reconsideration, including dismissals of such requests.¹⁰
- **Part A** or **Part B** contractor actions that do not involve initial determinations, including:¹¹
 - A MAC or QIC decision whether to reopen a determination or decision;
 - Determinations that a provider or supplier failed to submit a claim timely to the MAC; and
 - Determinations by the Secretary of sustained or high levels of payment errors in accordance with [section 1893\(f\)\(3\)\(A\) of the Act](#).
- **QIO** diagnosis related group (DRG) validations.¹²

Note: A QIO DRG validation occurs when a QIO reviews diagnostic or procedural coding information submitted by a hospital. If the QIO changes the DRG, that change could be subject to a reconsideration or reopening by the QIO, but no additional review or appeal is available. A QIO DRG validation is not to be confused with a DRG downcode conducted by a MAC or RAC, which is an issue that

⁶ 42 C.F.R. § 405.904(a)(1).

⁷ See 42 C.F.R. § 423.46(c); see also 74 Fed. Reg. 1494, 1502–03 (Jan. 12, 2009).

⁸ 20 C.F.R. §§ 418.1350, 418.2350.

⁹ 42 C.F.R. §§ 405.1004, 423.2004.

¹⁰ 42 C.F.R. §§ 450.972(e), 405.974(b)(3). See also [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#), § 50.9.

¹¹ 42 C.F.R. §§ 405.924, 405.926. See also [Medicare Claims Processing Manual](#), pub. 100-04, ch. 29, § 200(B) for a more comprehensive list of actions that are not initial determinations.

¹² 42 C.F.R. § 478.15(c).

qualifies as a Part A initial determination, and is therefore appealable to OMHA.

- **QIO** quality-of-care determinations.¹³

Note: If a QIO's quality-of-care determination resulted in a payment denial, the determination could be appealable under [section 1869 of the Act](#) as a QIO initial denial determination under [section 1154\(a\)\(2\) of the Act](#).

- **Part C** grievances (any complaint or dispute filed by an enrollee that does not constitute an organization determination), including quality-of-care grievances.¹⁴
- **Part D** grievances between an enrollee and Part D plan sponsor or other entity or individual through whom the Part D plan sponsor provides covered benefits.¹⁵

Note: Part C and Part D grievance procedures are separate and distinct from appeal procedures.¹⁶ Appeals to OMHA of matters that would qualify as a grievance are dismissed for no right to a hearing (see OCPM 11.1.4).

- **Part D** subsidy determinations or redeterminations.¹⁷
- **Part D** late enrollment penalty determinations or reconsiderations.¹⁸
- **SSA** reconsiderations of disability-related Medicare qualified government employee (MQGE) determinations.¹⁹
- Decisions to **reopen** or **not reopen** a determination or reconsideration.²⁰

¹³ See 42 C.F.R. § 478.14(a); cf. §§ 476.120–476.170.

¹⁴ 42 C.F.R. §§ 422.562(b), 422.564.

¹⁵ 42 C.F.R. § 423.564.

¹⁶ See 42 C.F.R. §§ 422.561, 423.560.

¹⁷ 42 C.F.R. § 423.774(c).

¹⁸ 42 C.F.R. § 423.46(c).

¹⁹ SSA conducts ALJ hearings and Council reviews on MQGE appeals because the principle issue is whether the appellant satisfies Title II disability criteria.

²⁰ 42 C.F.R. §§ 405.980(a)(5), 423.1980(a)(4).

- **Part 426** determinations on the validity of a Medicare contractor LCD or a Medicare NCD.²¹
- Actions subject to **part 498** appeal procedures (for example, Medicare provider or supplier enrollment denials or revocations).²²

Note: Claim denials resulting from revocations are appealable under [42 C.F.R. part 405, subpart I](#), if the appellant has remaining appeal rights.

11.1.3 Which appeals can be escalated to OMHA without a reconsideration?

Only requests for a **Part A** or **Part B QIC** reconsideration can be escalated to OMHA.²³ See [OCPM 7.5](#) for more information on escalations.

11.1.4 What do we do if there was no appealable action, or if it is unclear whether there was an appealable action?

If it is **clear** that there was no appealable action, the request is dismissed for no right to a hearing or review (see [OCPM 17.1.5](#)).

If it is **unclear** whether an action was appealable, contact the requesting individual or entity (or its representative, if a representative is involved) for an explanation. If this is done orally, execute a Report of Contact (OMHA-101) to document the telephone conversation and include a copy in the administrative record.

See OCPM 11.9.1 for procedures for contacting an appellant to address a procedural defect.

²¹ [Part 426](#) LCD and NCD reviews are conducted by the DAB, and DAB Civil Remedies Division ALJs. See also [42 C.F.R. §§ 405.1060\(b\), 405.1062\(c\)](#).

²² [Part 498](#) appeals are adjudicated by the DAB, and ALJs within the DAB Civil Remedies Division.

²³ [42 C.F.R. § 405.970\(c\)–\(e\)](#).

11.2 Standing to appeal

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11.2.1 What is standing?

Standing conveys to an individual or entity a right to a hearing or review by an adjudicator on the appealed matter. An individual's or entity's standing is determined by regulation, and financial interest in the outcome of the case is generally not a factor in determining standing. To have standing, an individual or entity must be a party to the matter being appealed. However, not all parties have standing to appeal.

If an appellant who is not a party with standing to appeal, or the representative of such an appellant, files a request for hearing or review, the adjudicator dismisses the request for no right to appeal (see [OCPM 17.1.5.2](#)).

Note: This section deals with standing to appeal. See [OCPM 4](#) for more in-depth information on party status.

11.2.2 Who has standing to appeal a reconsideration or request review of a dismissal issued by . . .

11.2.2.1 A Part A or Part B QIC?

Any party to the QIC's reconsideration or dismissal (see [OCPM 4.8](#)) may file a request for hearing or review with OMHA.²⁴

11.2.2.2 A Part C IRE?

Any party to the IRE's reconsideration or dismissal (see [OCPM 4.8](#)), **except the MAO**, may file a request for hearing or review with OMHA.²⁵

11.2.2.3 A Part D IRE?

Only the enrollee may file a request for hearing or review with OMHA, because the enrollee is the only party to an appeal of a Part D IRE's reconsideration or dismissal.²⁶

Note: No other individual or entity may file a request for hearing or review with OMHA, unless that individual or entity is an authorized or appointed

²⁴ 42 C.F.R. § 405.1002(a).

²⁵ 42 C.F.R. § 422.600(a).

²⁶ 42 C.F.R. § 423.2002.

representative of the enrollee, or a deceased enrollee's surviving spouse or estate with a financial interest in the case (see [OCPM 4.1.3](#)).

Note: At prior levels of appeal, the prescriber may request an appeal on behalf of an enrollee, but the prescriber may not do so at the OMHA level, *unless* appointed as a representative of the enrollee.²⁷

11.2.2.4 A QIO, under Part A or Part B?

Expedited determinations (subpart J appeals)

QIO expedited determinations regarding inpatient hospital discharges or terminations of services by a home health agency, skilled nursing facility, comprehensive outpatient rehabilitation facility, or hospice, are the most common type of QIO appeal under Part A or Part B. In these types of appeals, only the **beneficiary** has standing to file an appeal at the OMHA level.²⁸

Other types of QIO appeals under Part A or Part B

For **all other** QIO determinations made under [section 1869 of the Act](#) (that is, an initial determination made under [section 1154\(a\)\(2\) of the Act](#)²⁹), **any party** to the reconsideration or dismissal (see [OCPM 4.2.1](#)) may file a request for hearing or review with OMHA.

Example: A QIO denies a claim for inpatient hospital services because the services could have been provided on an outpatient basis. Because this type of payment denial falls under [section 1154\(a\)\(2\) of the Act](#) (by reference to section 1154(a)(1)(C)), any party to the reconsideration or dismissal may file a request for hearing or review with OMHA.

For QIO determinations made under Title XI or XVIII when [section 1869 of the Act](#) does not apply, only a **beneficiary** has standing to request a hearing by an ALJ, unless

²⁷ 42 C.F.R. §§ 423.580, 423.600.

²⁸ 42 C.F.R. §§ 405.1204, 405.1206.

²⁹ 42 C.F.R. § 405.900(b)(3). Section 1869 of the Act, as revised by section 521 of BIPA, provides appeal rights at paragraph (b)(1)(A) for determinations made under paragraph (a)(1), which explicitly incorporates QIO determinations made under 1154(a)(2) of the Act.

the appeal involves a QIO's DRG validation, which is not appealable to OMHA by any party (see OCPM 11.1.2).³⁰

11.2.2.5 A QIO, under Part C?

Only the **enrollee** has standing to request a hearing for QIO determinations made under [section 1155 of the Act](#) and QIO determinations regarding inpatient hospital discharges or terminations of home health, skilled nursing facility, or comprehensive outpatient rehabilitation facility services by the provider or MAO.³¹

11.2.2.6 SSA?

Any party to the SSA reconsideration (see [OCPM 4.6](#)) may file a request for hearing or review with OMHA.

11.2.3 Which parties have standing to escalate a request for a Part A or Part B QIC reconsideration?

Only the **party who filed** the request for a **Part A** or **Part B QIC** reconsideration has the right to escalate the appeal to OMHA.³²

<i>Note:</i> The other parties to the claim remain parties to an escalated appeal.
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11.2.4 What do we do if the appellant does not have standing to appeal, or if it is unclear whether the appellant has standing to appeal?

If it is **clear** that the appellant was not a party with standing to appeal, the request for hearing or review is dismissed for no right to a hearing or review (see [OCPM 17.1.5](#)).

If it is **unclear** whether the appellant was a party with standing to appeal, contact the requesting individual or entity (see [OCPM 11.9.1](#)) (or its representative, if a representative is involved) for an explanation.

³⁰ [42 C.F.R. § 478.40](#). Under section 1155 of the Act, a beneficiary, provider, or practitioner may request a reconsideration from the QIO of the QIO's determination. However, section 1155 of the Act authorizes only the beneficiary to request a hearing by an ALJ to review a QIO reconsideration of a QIO determination.

³¹ [42 C.F.R. §§ 422.622\(g\), 422.626\(g\)](#).

³² [42 C.F.R. § 405.1002\(b\)](#).

11.2.5 What do we do if the appeal was filed by a representative who is not authorized or validly appointed, or if it is unclear whether the representative is authorized or validly appointed?

See [OCPM 5](#) for general information on representatives. Specifically, see [OCPM 5.2.7](#) regarding procedures for providing an opportunity to cure an invalid authorization or appointment of representative.

11.3 Amount in controversy

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11.3.1 What is the AIC requirement?

The AIC requirement is the statutory threshold monetary amount that a party with standing to appeal must meet to be entitled to a hearing or review of a dismissal (*see* OCPM 11.2.1).

If the appeal does not meet the minimum AIC, the request for hearing or review is subject to dismissal (*see* [OCPM 17.1.5.4](#)).

11.3.2 What is the minimum AIC required for a hearing or review of a dismissal?

For all appeals (other than QIO reconsidered determinations and dismissals where section 1869 of the Act does not apply)

The statute established the initial AIC, and directed that it be adjusted annually for inflation. Pursuant to that directive, CMS revises the minimum AIC annually based on the statutory formula and publishes notice of the revision in the Federal Register. The following table provides the minimum AIC based on the calendar year in which the request for hearing or review was received, for the ten most recent calendar years:

Calendar Year	Minimum AIC	Federal Register Publication
2022	\$180	86 Fed. Reg. 54198 (Sept. 30, 2021)
2021	\$180	85 Fed. Reg. 60795 (Sept. 28, 2020)
2020	\$170	84 Fed. Reg. 53444 (Oct. 7, 2019)
2019	\$160	83 Fed. Reg. 47619 (Sept. 20, 2018)
2018	\$160	82 Fed. Reg. 45592 (Sept. 29, 2017)
2017	\$160	81 Fed. Reg. 65651 (Sept. 23, 2016)
2016	\$150	80 Fed. Reg. 57827 (Sept. 25, 2015)
2015	\$150	79 Fed. Reg. 57933 (Sept. 26, 2014)
2014	\$140	78 Fed. Reg. 59702 (Sept. 27, 2013)
2013	\$140	77 Fed. Reg. 59618 (Sept. 28, 2012)

QIO appeals under *section 1155 of the Act* when *section 1869 of the Act* does not apply³³

For appeals of QIO reconsidered determinations and dismissals where [section 1869 of the Act](#) does not apply, the minimum AIC required for an ALJ hearing or review of a dismissal is \$200.³⁴ This amount does not adjust annually.

Note: [Sections 1852\(g\)\(5\) and 1876\(c\)\(5\) of the Act](#) provide that a hearing is available to a Part C or cost plan enrollee if the AIC is \$100 or more, as adjusted annually in accordance with [section 1869](#), without regard to which entity made the reconsideration being appealed.

11.3.3 Which calendar year AIC applies to a request for hearing, review, or escalation?

Apply the minimum AIC for the calendar year in which the office or entity identified in the reconsideration or escalation instructions received the request.

Example: An appellant files a request for hearing appealing a QIC reconsideration. The request is postmarked December 31, 2016, and is received by OMHA on January 2, 2017. The minimum AIC for calendar year 2017 (\$160) applies.

Example: An appellant files a request for hearing appealing an SSA reconsideration. SSA receives the request on December 31, 2016, and forwards it to OMHA, which receives the request on January 2, 2017. The minimum AIC for calendar year 2016 (\$150) applies because SSA reconsideration appeal instructions direct the appellant to file requests for hearing with SSA.

11.3.4 Who determines whether the minimum required AIC is met?

In providing appeal rights and instructions for requesting a hearing or review, the entity issuing the reconsideration or dismissal may make an initial assessment or estimation of whether the minimum AIC required for a hearing or review of a dismissal is met.³⁵ However, this initial assessment or estimation is not conclusive on the matter. The

³³ Despite any direct inconsistencies with [42 C.F.R. section 478.40](#), the annually adjusted amount in controversy applies to QIO appeals when [section 1869 of the Act](#) applies (for example, appeals of inpatient hospital discharges). See [69 Fed. Reg. 69251, 69260 \(Nov. 26, 2004\)](#).

³⁴ [§ 1155 of the Act](#); [42 C.F.R. § 478.40](#). BIPA expanded the scope of [section 1869 of the Act](#) to include application to initial determinations made under [Title XI of the Act](#) and subsequent appeals. [CMS Ruling 02-01](#) aligned the minimum AIC threshold for appeals of a QIO reconsideration with the threshold established by BIPA (\$100, adjusted annually) for appeals of QIO initial determinations specified in section 521 of BIPA.

³⁵ See, e.g., [42 C.F.R. § 405.976\(b\)\(7\)](#).

OMHA adjudicator is responsible for determining whether the AIC is met, although an exact calculation is not always required (see OCPM 11.3.5).

Note: In a **Part C** or **Part D** appeal, the MA plan or Part D plan sponsor may be asked to assist in the computation of the AIC when necessary. If necessary, contact the **Appeals Policy and Operations Division** for assistance in obtaining the requested information.

11.3.5 When can we presume an appeal satisfies the minimum AIC?

An exact calculation of the AIC is not necessary when the record indicates:

- The amount charged for the item or service at issue is well in excess of the minimum AIC, and no partial payment has been made.

Example: A remittance advice for a non-covered Part B claim indicates the amount charged is more than 20 percent above the minimum AIC, and no portion of the claim has been paid.

- The appellant is appealing a claim that is part of a larger MSP recovery action or an extrapolated overpayment, and the MSP recovery action or extrapolated overpayment clearly exceeds the minimum AIC.
- The matter appealed is one that generally meets the minimum AIC, unless the record suggests otherwise.

Example: The value of an individual's entitlement to the Medicare program always exceeds the minimum AIC.

11.3.6 How do we calculate the AIC for a . . .

11.3.6.1 Part A or Part B prepayment denial³⁶ of furnished items or services?

For each claim at issue, calculate the AIC as follows:

Step one. Find the actual **amount charged the individual** for the claim at issue (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).

³⁶ Prepayment denials occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination.

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 (claim line items) that were paid, such as some, but not all, components of a DME item).

Step three. Subtract any applicable deductible or coinsurance amounts that may be collected for the items or services on the claim (for example, the 20-percent coinsurance on the allowable Medicare amount³⁷ that is generally required for certain assigned Part B claims).³⁸

Example: OMHA receives a request for hearing in 2019 involving a 2018 Part A hospital inpatient claim for fewer than 61 days with billed charges of \$8,679 that was denied in full. At the time the services were provided, the beneficiary had not paid anything toward her 2018 Part A deductible. Calculate the AIC as follows:

$$\begin{aligned} & \$8,769 \text{ (billed charges)} \\ & \quad \textit{less } \$0 \text{ (Medicare payments made)} \\ & \quad \textit{less } \$1340 \text{ (2018 Part A deductible)} \\ & = \$7,429 \end{aligned}$$

The AIC requirement for 2019 (\$160) is met.

Example: OMHA receives a request for hearing in 2015 involving a Part B claim for diabetic testing supplies furnished by a participating supplier with billed charges of \$400, with an allowable amount of \$300 if it was fully covered. The claim was decided partially favorably at the reconsideration level, and Medicare paid \$250. Calculate the AIC as follows:

$$\begin{aligned} & \$400 \text{ (billed charges)} \\ & \quad \textit{less } \$250 \text{ (Medicare payments made)} \\ & \quad \textit{less } \$60 \text{ (20-percent Part B copayment on allowable } \$300) \end{aligned}$$

³⁷ Note that the allowable amount, and therefore the Part B coinsurance, may differ based on whether a supplier (including a physician) is a participating or non-participating supplier, and for non-participating suppliers, whether the supplier took assignment of the claim. For example, a \$100 allowable amount for a participating supplier yields \$20 as the 20% Part B coinsurance. However, also note that, in calculating the AIC, the amount charged is used; if a participating supplier charged \$200 for a service with a \$100 allowable amount, and the claim was denied in full, the AIC would be \$180 (amount charged—\$200, less Medicare payments made on the claim—\$0, less Part B 20% coinsurance on the allowed amount for an assigned claim by a participating supplier—\$20).

³⁸ 42 C.F.R. § 405.1006(d)(1).

= \$90

The AIC requirement for 2015 (\$150) is not met.

Note: When payment is made under the limitation on liability provisions,³⁹ or a beneficiary's liability is limited under those provisions,⁴⁰ the AIC is calculated as the amount the beneficiary would have been charged for the items or services in question if payment had not been made or if liability had not been limited, reduced by any deductible or coinsurance amounts that may be collected.⁴¹

11.3.6.2 Part A or Part B hospital discharge or provider termination of service?

Calculate the AIC as in OCPM 11.3.6.1, basing the amount charged the individual on one of the following:

- If continued services **were furnished** after the disputed date of discharge or termination of Medicare-covered services, use the actual charges for services furnished after the disputed discharge or termination; or
- If continued services **were not furnished** after the disputed date of discharge or termination of Medicare-covered services, use the amount the beneficiary would have been charged if the beneficiary had received the services the beneficiary asserts should be covered based on his or her current condition.⁴²

Note: If the beneficiary did not receive continued services, and the beneficiary is **deceased**, the minimum AIC cannot be met because the beneficiary did not receive any services for which he or she could be charged.⁴³

11.3.6.3 Part A or Part B overpayment for furnished items or services?

The AIC is the amount of the overpayment specified in the demand letter for the items or services in the disputed claim.⁴⁴

³⁹ See 42 CFR § 411.400.

⁴⁰ See 42 CFR § 411.402.

⁴¹ 42 C.F.R. § 405.1006(d)(2).

⁴² 42 C.F.R. § 405.1006(d)(3).

⁴³ *Id.*

⁴⁴ 42 C.F.R. § 405.1006(d)(4).

For overpayments determined through the use of **statistical sampling and extrapolation**, use the total amount of the estimated overpayment as specified in the demand letter.⁴⁵

If the amount originally demanded is revised as a result of a subsequent determination or appeal, the AIC is the amount of the revised overpayment or estimated overpayment.⁴⁶

11.3.6.4 Part A or Part B MSP recovery?

MSP recovery actions are a type of overpayment. Calculate the AIC as in OCPM 11.3.6.3.⁴⁷

11.3.6.5 Part A or Part B coinsurance or deductible dispute?

The AIC is the amount of coinsurance or remaining deductible calculated by the contractor, reduced by the amount of coinsurance or deductible the beneficiary believes is correct.⁴⁸

Example: A hospital seeks **Part B** coverage for a diagnostic colonoscopy provided to the beneficiary as an outpatient. Medicare pays the provider the full amount allowed for the colonoscopy and indicates in a summary notice that the beneficiary may be billed a coinsurance amount of \$924.25. The beneficiary appeals the computation of the coinsurance amount, asserting that no coinsurance should be due because the colonoscopy was a screening test furnished by a provider that accepted assignment. Calculate the AIC as follows:

$$\begin{aligned} & \$924.25 \text{ (amount calculated by the contractor)} \\ & \quad \textit{less} \ \$0 \text{ (amount beneficiary believes is correct)} \\ & = \$924.25 \end{aligned}$$

The AIC requirement is met.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.* 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 42 C.F.R. § 411.37.

⁴⁸ 42 C.F.R. § 405.1006(d)(5).

11.3.6.6 Part A or Part B fee schedule or contractor price challenge (allowable amount has been paid in full)?

The AIC is the amount that the appellant argues should have been the Medicare allowed amount or contractor-priced amount for the item or service in the disputed claim in the applicable jurisdiction and place of service, reduced by the published allowable or contractor-priced amount.⁴⁹

11.3.6.7 Part C denied item or service already furnished?

For each item or service at issue, calculate the AIC as follows:

Step one. Find the actual amount charged the enrollee.

Step two. Subtract any payments already made by the MAO (for example, the amount paid for a lower, allowed level of service).

Step three. Subtract any applicable deductible or coinsurance amounts that may be collected for the items or services on the claim (for example, a 20-percent coinsurance required under the MA plan's evidence of coverage).⁵⁰

Note: The AIC in a **Part C** appeal is calculated in accordance with [42 C.F.R. section 405.1006](#).⁵¹ While Medicare **Part A** and **Part B** use deductibles and coinsurance (where the beneficiary pays a percentage of the cost for an item or service) as forms of cost sharing, MA plans may also use copayments (where the enrollee pays a flat fee for an item or service). For purposes of calculating the AIC for a **Part C** appeal, include the amount of any applicable copayments due under the MA plan in the deduction in step three.

11.3.6.8 Part C plan refusals to provide an item or service?

The AIC is the projected value of the item or service.⁵² If optional or supplemental benefits are involved, but not employer-sponsored benefits limited to employer group members, use the projected value of those benefits to determine whether the AIC is met.

⁴⁹ 42 C.F.R. § 405.1006(d)(6).

⁵⁰ 42 C.F.R. §§ 405.1006(d)(1), 422.600(b). See also *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*, § 70.2.

⁵¹ 42 C.F.R. § 422.600(b).

⁵² *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*, § 70.2.

11.3.6.9 Part C cost-sharing dispute?

The AIC is the amount of the coinsurance, copayment, or remaining deductible calculated by the plan or IRE, reduced by the amount of coinsurance, copayment, or deductible the enrollee believes is correct.⁵³

Note: The AIC in a **Part C** appeal is calculated in accordance with [42 C.F.R. section 405.1006](#).⁵⁴ While Medicare **Part A** and **Part B** use deductibles and coinsurance (where the beneficiary pays a percentage of the cost for an item or service) as forms of cost sharing, MA plans may also use copayments (where the enrollee pays a flat fee for an item or service). For purposes of calculating the AIC for a **Part C** cost-sharing dispute involving a copayment, calculate the AIC in the same manner as for deductible and coinsurance challenges, but using the copayment due under the MA plan.

Note: General dissatisfaction about a copayment amount, but not a dispute about the amount the enrollee paid or was billed, is a type of grievance.⁵⁵

11.3.6.10 Part D refusal to provide prescription drug benefits?

For each disputed drug at issue, calculate the AIC as follows:

Step one. Find the projected value of the drug benefits in dispute, taking into consideration:

- Any costs the enrollee could incur based on the number of refills prescribed for the drug(s) in dispute for the plan year;
- Any expenditures incurred after an enrollee's expenditures exceed the initial coverage limit; and
- Any expenditures paid by other entities (for example, secondary insurers).

Step two. Subtract any allowed amount under Part D.

⁵³ [42 C.F.R. §§ 405.1006\(d\)\(5\), 422.600\(b\)](#).

⁵⁴ [42 C.F.R. § 422.600\(b\)](#).

⁵⁵ [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, § 30.1](#)

Step three. Subtract any applicable deductible, copayment, and coinsurance amounts.⁵⁶

11.3.6.11 Part D enrollee seeking reimbursement for out-of-pocket costs incurred in obtaining a disputed Part D drug?

For each disputed drug at issue, calculate the AIC as follows:

Step one. Find the actual amount charged the enrollee or third party for the drug(s).

Step two. Subtract any allowed amount under Part D.

Step three. Subtract any applicable deductible, copayment, and coinsurance amounts.⁵⁷

11.3.6.12 Part D cost-sharing dispute?

The AIC is the amount of coinsurance, copayment, or remaining deductible calculated by the plan or IRE for each disputed drug, reduced by the amount of coinsurance, copayment, or deductible the enrollee believes is correct.⁵⁸

11.3.6.13 Part D at-risk determination made under a drug management program?

The AIC is the projected value of the drugs subject to the drug management program.⁵⁹ See OCPM 11.3.6.10 for instructions on calculating the projected value of a drug.

11.3.6.14 SSA eligibility/entitlement determination?

Unless the record indicates otherwise, presume that the minimum AIC is met. The AIC is the cost of self-insurance or accrued medical bills during the period of the disputed benefit, reduced by the amount of any Medicare premiums, coinsurance, or copayments the beneficiary would have paid.

⁵⁶ 42 C.F.R. §§ 423.1970(b) (2018) (for appeals filed before July 8, 2019), 423.2006(c) (for appeals filed on or after July 8, 2019); [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, § 70.2](#).

⁵⁷ 42 C.F.R. §§ 423.1970(b) (2018) (for appeals filed before July 8, 2019), 423.2006(c) (for appeals filed on or after July 8, 2019); [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, § 70.2](#).

⁵⁸ 42 C.F.R. §§ 423.566(b)(5).

⁵⁹ 42 C.F.R. §§ 423.1970(b)(2) (2018) (for appeals filed before July 8, 2019), 423.2006(c)(2) (for appeals filed on or after July 8, 2019).

11.3.6.15 SSA Part B late enrollment penalty determination?

Unless the record indicates otherwise, presume that the minimum AIC is met. The AIC is the monthly increase in the Part B premium due to the penalty, which is ongoing from the date of assessment, assuming the penalty is not overturned.

Example: A deceased beneficiary's successor disputes SSA's assessment of a 10-percent Part B late enrollment penalty beginning in January 2018. The amount of the adjustment was \$13.40 per month, and the beneficiary, who died on February 28, 2018, paid the adjusted premium for two months. In this case, the AIC is \$26.80, and the presumption that the minimum AIC was met is rebutted.

11.3.6.16 SSA IRMAA determination?

The AIC is the disputed increase in the beneficiary's premium for the year the IRMAA assessment covers for Medicare Part B and, if applicable, Part D.

Example: Based on the beneficiary's tax return for the 2016 tax year, SSA assessed an IRMAA for 2018. The beneficiary disputes SSA's assessment of a \$42.00 increase in the monthly Medicare Part B premium for 2018, as well as a \$12.10 increase in the beneficiary's monthly plan premium for Medicare Part D (for a total monthly increase of \$54.10). Since all 12 months of 2018 premiums would be affected by the premium increase, the AIC is $12 \times \$54.10 = \649.20 (the monthly IRMAA for both Medicare Part B and Part D).

11.3.6.17 Dismissal review?

The AIC is the AIC for the underlying matter that was appealed to the QIC or IRE, calculated in accordance with OCPM 11.3.6.1 through 11.3.6.13.

Example: If a Part A QIC dismissed a request for reconsideration of a prepayment denial of furnished items or services, calculate the AIC in accordance with OCPM 11.3.6.1.

11.3.7 What is aggregation?

Disputed **Part A** or **Part B** claims, **Part C** items or services, and **Part D** prescription drugs may be considered together (aggregated) to meet the minimum AIC when any of the claims, items or services, or prescription drugs do not individually meet the AIC.⁶⁰

- Aggregation may occur among claims, Part C items or services, or prescription drugs that each do not individually meet the minimum AIC, or among some that do not meet the minimum AIC and some that do meet the minimum AIC.
- **Part A** and **Part B** claims may be considered together for aggregation, as may **Part C** items or services that involve Part A and Part B benefits.⁶¹
- An individual appellant or multiple appellants may aggregate two or more claims, Part C items or services, or prescription drugs, to meet the minimum AIC.⁶²

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.

Note: If an appellant requests aggregation and one or more of the claims in the aggregation request are subsequently involved in an alternative appeal resolution method (for example, a settlement authorized by CMS), the claim(s) will be removed from the aggregation request. However, for purposes of calculating the AIC, the removed claims are considered by the adjudicator.

11.3.8 What are the criteria for aggregation?

Aggregation must be requested, and is only available when:

- An ALJ or attorney adjudicator determines that the claims, Part C items or services, or prescription drugs that the appellant seeks to aggregate **meet the criteria for relatedness** (*see* OCPM 11.3.8.1);
- The request for aggregation **contains the required elements** (*see* OCPM 11.3.8.2);

⁶⁰ 42 C.F.R. §§ 405.1006(e), 422.600(b), 423.1970(c) (2018) (for appeals filed before July 8, 2019), 423.2006(d) (for appeals filed on or after July 8, 2019).

⁶¹ 42 C.F.R. §§ 405.1006(e)(1)(iii), (e)(2)(iii), 422.600(b).

⁶² 42 C.F.R. §§ 405.1006(e)(1), (e)(2), 423.1970(c)(2) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(2) (for appeals filed on or after July 8, 2019).

- The request for aggregation is **timely filed** (*see* OCPM 11.3.8.3); and
- The claims, Part C items or services, or prescription drugs that the appellant seeks to aggregate were **all** reconsidered or dismissed, or the claims were **all** pending before the QIC with the same request for reconsideration that is escalated to OMHA (*see* OCPM 11.3.8.4).

11.3.8.1 How must the claims, services, or prescription drugs the appellant seeks to aggregate be related?

Part A, Part B, and Part C appeals (single appellant)⁶³

- The **Part A** and **Part B** claims, or **Part C** items or services, must involve the delivery of similar or related services; and

Note: “Delivery of similar or related services” means like or coordinated services or items provided to one or more beneficiaries.⁶⁴

- All claims or Part C items or services must have been reconsidered, or the request(s) for reconsideration must have all been dismissed; or all claims must have all been pending before the **Part A** or **Part B QIC** in conjunction with the same request for reconsideration that is escalated to OMHA.

Part A, Part B, and Part C appeals (multiple appellants)⁶⁵

- The **Part A** and **Part B** claims, or **Part C** items or services, must involve common issues of law and fact; and

Note: “Common issues of law and fact” means the claims, or Part C items or services, are denied, or payment is reduced, for similar reasons and arise from a similar fact pattern material to the reason the claims, or Part C items or services, are denied or payment is reduced.⁶⁶

- All claims or Part C items or services must have been reconsidered, or the request(s) for reconsideration must have all been dismissed; or all claims

⁶³ 42 C.F.R. §§ 405.1006(e)(1)(iii), (e)(2)(iii), 422.600(b).

⁶⁴ 42 C.F.R. § 405.1006(a)(2).

⁶⁵ 42 C.F.R. §§ 405.1006(e)(1)(iii), (e)(2)(iii), 422.600(b).

⁶⁶ 42 C.F.R. § 405.1006(a)(1).

must have all been pending before the **Part A** or **Part B QIC** in conjunction with the same request for reconsideration that is escalated to OMHA.

Part D appeals (single enrollee)

- The appeals must involve delivery of prescription drugs to a single enrollee; and
- The appeals must all have been reconsidered, or the requests for reconsideration must all have been dismissed.

Part D appeals (multiple enrollees)

- The appeals must involve delivery of the same prescription drug to multiple enrollees; and
- The appeals must all have been reconsidered, or the requests for reconsideration must all have been dismissed.

11.3.8.2 What are the required elements for a valid aggregation request?

Requests for hearing or review

For **Part A**, **Part B**, and **Part C** appeals, the request for aggregation must:

- List all the claims or Part C items or services to be aggregated,⁶⁷ and
- State why the appellant believes:
 - Claims or Part C items or services that a **single appellant** wishes to aggregate involve the delivery of similar or related services; or
 - Claims or Part C items or services that **multiple appellants** wish to aggregate involve common issues of law and fact.⁶⁸

Note: For **Part D** appeals, the requests and records together must establish the appeals that a single enrollee wishes to aggregate involve prescription drugs delivered to that enrollee,⁶⁹ or the appeals that multiple enrollees wish to aggregate involve the same prescription drug delivered to the

⁶⁷ 42 C.F.R. §§ 405.1006(e)(1)(ii), (f)(1).

⁶⁸ 42 C.F.R. §§ 405.1006(e)(1)(iii), (f)(2).

⁶⁹ 42 C.F.R. §§ 423.1970(c)(1)(iii) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(1)(iii) (for appeals filed on or after July 8, 2019).

enrollees,⁷⁰ but neither has to be stated in a request, and the prescription drugs the enrollee(s) wish to aggregate do not need to be listed in the request.

Note: A **Part A**, **Part B**, or **Part C** 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 **Part B** claims the supplier seeks to aggregate and explains that the claims involve similar or related items provided to multiple beneficiaries, the requirements for requesting aggregation are met. However, an ALJ or attorney adjudicator must still determine that the claims involve delivery of similar or related items, though only an ALJ may determine that they do not.⁷¹

Requests for escalation from a QIC to OMHA

The request for aggregation must:

- List all the claims to be aggregated in the same request for escalation;⁷² and
- State why the appellant believes:
 - Claims that a **single appellant** wishes to aggregate involve the delivery of similar or related services; or
 - Claims that **multiple appellants** wish to aggregate involve common issues of law and fact.⁷³

Note: A **Part A**, **Part B**, or **Part C** request does not have to use the term “aggregate” or specifically mention meeting the AIC requirement.

⁷⁰ 42 C.F.R. §§ 423.1970(c)(2)(iii) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(2)(iii) (for appeals filed on or after July 8, 2019).

⁷¹ 42 C.F.R. § 405.1006(e)(1)(iii).

⁷² 42 C.F.R. § 405.1006(e)(2)(ii), (f)(1).

⁷³ 42 C.F.R. § 405.1006(e)(2)(iii), (f)(2).

11.3.8.3 When does the aggregation request have to be filed?

Requests for hearing or review

The request for aggregation must be:

- Filed with or made part of the request(s) for hearing or review for all of the claims, Part C items or services, or prescription drugs to be aggregated; and
- Filed within 60 calendar days of receiving the notice of reconsideration or dismissal of the reconsideration request for each appealed claim, Part C item or service, or prescription drug to be aggregated, unless the appellant establishes good cause for an untimely request.⁷⁴

Note: An appellant may not aggregate claims, Part C items or services, or prescription drugs in a new request for hearing or review with claims, Part C items or services, or prescription drugs in a previously filed request.⁷⁵ If such a request is made, the request for aggregation and the newly filed request for hearing or review are considered without regard to the previously filed request.

Requests for escalation from a QIC to OMHA

The request for aggregation must be filed with the request for escalation.⁷⁶

Note: An appellant may not aggregate claims in a new request for escalation with claims in a previously filed request.⁷⁷ If such a request is made, the request for aggregation and the newly filed request for escalation are considered without regard to the previously filed request.

⁷⁴ 42 C.F.R. §§ 405.1006(e)(1)(ii), 42 C.F.R. §§ 423.1970(c)(1)(ii), (c)(2)(ii) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(1)(ii), (d)(2)(ii) (for appeals filed on or after July 8, 2019).

⁷⁵ 42 C.F.R. §§ 405.1006(e)(1)(ii), 42 C.F.R. §§ 423.1970(c)(1)(ii), (c)(2)(ii) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(1)(ii), (d)(2)(ii) (for appeals filed on or after July 8, 2019). *See also* 82 Fed. Reg. 4974, 5009 (Jan. 17, 2017).

⁷⁶ 42 C.F.R. § 405.1006(e)(2)(ii).

⁷⁷ 42 C.F.R. §§ 405.1006(e)(1)(ii), 42 C.F.R. §§ 423.1970(c)(1)(ii), (c)(2)(ii) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(1)(ii), (d)(2)(ii) (for appeals filed on or after July 8, 2019). *See also* 82 Fed. Reg. 4974, 5009 (Jan. 17, 2017).

11.3.8.4 Is there a requirement that the claims, Part C items or services, or prescription drug appeals the appellant seeks to aggregate all be reconsidered?

To be eligible for aggregation:

- The claims, Part C items or services, or prescription drug appeals must all have been reconsidered; or
- The request(s) for reconsideration must all have been dismissed; or
- The claims must have all been pending before the Part A or Part B QIC in conjunction with the same request for reconsideration that is escalated to OMHA.

11.3.8.5 How do we respond to an aggregation request?

Granted requests

If the request for aggregation was valid (*see* OCPM 11.3.8.2), timely filed (*see* OCPM 11.3.8.3), and the claims, Part C items or services, or prescription drug appeals met the criteria in OCPM 11.3.8.4, and an adjudicator determines that criteria for aggregating the claims, Part C items or services, or prescription drugs are met (*see* OCPM 11.3.8.1), document the determination to grant the aggregation request, along with the requisite analysis and findings, in the decision or other disposition document.

Denied requests

If the request for aggregation was valid (*see* OCPM 11.3.8.2), timely filed (*see* OCPM 11.3.8.3), and the claims, Part C items or services, or prescription drug appeals met the criteria in OCPM 11.3.8.4, but an **ALJ** determines that the criteria for aggregating the claims, Part C items or services, or prescription drugs are not met (*see* OCPM 11.3.8.1), document the determination to deny the aggregation request in each dismissal order or other disposition document.

Note: If an **attorney adjudicator** is assigned to an appeal and does not believe the criteria for granting an aggregation request are met, transfer the

appeal to an ALJ for a determination on the aggregation request and subsequent adjudication of the appeal.⁷⁸

Invalid requests

Calculate the AIC for the individual claims, organization determinations, or prescription drug appeals without regard to the request for aggregation if the request:

- Did not contain the required elements (*see* OCPM 11.3.8.2);
- Was untimely filed (*see* OPCM 11.3.8.3); or
- Sought to aggregate claims, Part C items or services, or prescription drugs appeals that were not reconsidered or the reconsideration request for which was not dismissed; or sought to aggregate claims in an escalation that were not part of the escalated reconsideration request (*see* OCPM 11.3.8.4).

Document the determination that the aggregation request was invalid in each dismissal order or other disposition document.

Partially invalid or denied requests

If an aggregation request is deemed invalid or denied with respect to one or more, but not all, of the claims, Part C items or services, or prescription drugs an appellant seeks to aggregate, the claims, Part C items or services, or prescription drugs with respect to which the aggregation request is deemed invalid or denied are removed from the aggregation request. Any removed claims, Part C items or services, or prescription drug appeals that do not individually meet the AIC are dismissed. The dismissal order must document the reason(s) the request for aggregation was invalid with respect to the removed claims, Part C items or services, or prescription drugs.

- If the remaining, validly aggregated claims, Part C items or services, or prescription drugs still **meet** the minimum AIC, document the findings and analysis for the removal of the invalid or denied claims, Part C items or services, or prescription drugs in the decision or other disposition document for the remaining claims, Part C items or services, or prescription drugs.

⁷⁸ See 42 C.F.R. §§ 405.1006(e)(1)(iii), (e)(2)(iii), 423.1970(c)(1)(iii), (c)(2)(iii) (2018) (for appeals filed before July 8, 2019), 423.2006(d)(1)(iii), (d)(2)(iii) (for appeals filed on or after July 8, 2019).

- If the remaining, validly aggregated claims, Part C items or services, or prescription drugs **do not** meet the minimum AIC, document the determination with respect to the aggregation request, along with the requisite analysis and findings, in the dismissal order.

If the claims, Part C items or services, or prescription drugs are associated with a single OMHA appeal number, the ALJ issues a single disposition document that addresses the dismissal of any removed claims, Part C items or services, or prescription drugs; and the disposition of the remaining claims, Part C items or services, or prescription drugs. Alternatively, the ALJ may request that the appeal be uncombined to remove the claim that did not meet the relatedness criteria from the appeal so it can be separately dismissed (see [OCPM 9.9.2.2](#)).

Example: An appellant files a request seeking to aggregate three claims that were separately adjudicated at the reconsideration level and that each have an individual AIC of \$80. OMHA combines the appeals into a single OMHA appeal number. The minimum AIC required for an ALJ hearing at the time the request is filed is \$160. An ALJ determines that one of the three claims did not meet the aggregation requirement for relatedness. After removing that claim from the aggregation request, the remaining two claims still meet the minimum AIC of \$160. The ALJ may issue a single disposition document that addresses: (1) the removal of the claim that did not meet the relatedness criteria from the aggregation request, and the resulting dismissal of the request for hearing with respect to that claim for failure to meet the minimum AIC; and (2) the disposition on the remaining claims. Alternatively, the ALJ may request that the appeal be uncombined to remove the claim that did not meet the relatedness criteria from the appeal so it can be separately dismissed

11.3.9 What do we do if the AIC is not met, or it is unclear whether the AIC is met?

All appeals other than QIO reconsidered determinations and dismissals

If it is **clear** that the minimum required AIC is not met, the request for hearing or review is dismissed for no right to a hearing or review (see [OCPM 17.1.5](#)).

If it is **unclear** whether the minimum required AIC is met, contact the requesting individual or entity (or representative, if a representative is involved) to provide an

opportunity to furnish additional information or evidence to demonstrate the AIC or the criteria for aggregation are met.

See OCPM 11.9.1 for procedures for contacting an appellant to address a procedural defect.

Appeals of QIO reconsidered determinations and dismissals

For appeals under [section 1155 of the Act](#) of QIO reconsidered determinations, an opportunity to cure the defect **must** be provided, even if it appears clear that the AIC is not met.⁷⁹

See OCPM 11.9.1 for procedures for contacting an appellant to address a procedural defect.

Note: Under [42 C.F.R. section 478.44](#), if an ALJ or attorney adjudicator believes the AIC is less than \$200, the parties must be provided 15 calendar days to submit additional evidence to demonstrate the AIC is at least \$200 before an ALJ may dismiss the request. However, for consistency with the time afforded to cure other procedural defects, OMHA allows 20 calendar days for the parties to submit additional evidence.

⁷⁹ [42 C.F.R. § 478.44\(b\)](#).

11.4 Timely filing

(Issued: 12-09-2021, Effective: 12-09-2021)

11.4.1 When is a request for hearing or review timely filed?

A request for hearing or review must be filed within 60 calendar days after receiving a notice of reconsideration or notice of dismissal, or there must be a finding of good cause for a late request.⁸⁰ If there is no request for an extension and if there is no requirement under OCPM 11.4.6.4 to follow up with the party for the reasons why the request is late, a request filed beyond the 60 calendar day filing period must be dismissed.

Note: This section does not apply to cases that are escalated to OMHA. Escalation requests are filed with the **Part A** or **Part B QIC** and are not subject to a timely filing requirement.⁸¹

Note: For appeals that involve a disagreement with how a statistical sample and/or extrapolation was conducted and that are filed on or after March 20, 2017, the request for hearing for all sampled claims the appellant wishes to appeal must be filed within 60 calendar days after the party receives the last reconsideration for the sample claims, if the sample claims were not all addressed in a single reconsideration.⁸²

11.4.2 When does the 60 calendar day filing time frame start . . .

11.4.2.1 When there is no evidence of actual receipt?

Unless there is evidence to the contrary, presume that the notice of reconsideration or dismissal was received by the party or the party's representative five calendar days after the date of the notice.⁸³

Example: A QIC issues a notice of reconsideration on Monday, February 4, 2019. The record does not indicate the date the appellant actually received the notice, so the 5 calendar day presumption applies and the 60 calendar day filing period begins on Saturday, February 9, 2019. Applying the 60

⁸⁰ 20 C.F.R. § 404.933(b); 42 C.F.R. §§ 405.1014(c), (e), 422.602(b), 423.2014(d), (e), 478.42(b).

⁸¹ See 42 C.F.R. § 405.970(d).

⁸² 42 C.F.R. § 405.1014(a)(3)(ii). The sampled claim involved in the last reconsideration does not have to be an appealed claim—the claim could be favorable or involve an item or service the appellant does not wish to appeal.

⁸³ 42 C.F.R. §§ 405.1002(a)(3), 405.1004(a)(3), 422.602(b)(2), 423.2002(d), 423.2004(a)(3), 478.42(b)(2).

calendar day filing period, the request for hearing must be filed no later than Wednesday, April 10, 2019.

11.4.2.2 When there is evidence of actual receipt?

If the appellant provides evidence of the actual receipt date, use that date to determine the timeliness of the request. If that date is more than 5 calendar days after the date of the notice and the request was filed within 60 calendar days of the actual receipt date, a good cause determination is not necessary because the request is not late. Rather, the evidence serves to rebut the presumption that the notice was received five calendar days after the date of the notice.

Example: If the appellant includes a copy of the reconsideration notice with a date stamp indicating when the appellant received it, use this date as evidence of actual receipt for purposes of calculating the timeliness of the request for hearing or review.

11.4.3 What do we do if the filing deadline falls on a weekend, holiday, or another day the office is closed?

When the last day for filing a request for hearing falls on a weekend, Federal holiday, or any other day that the receiving office (*see* [OCPM 9.1.5](#)) is closed for business (for example, due to inclement weather), the filing period is extended to the next business day that the receiving office is open for business.

Example: The QIC issues a reconsideration notice on Tuesday, September 18, 2018. Applying the 5 calendar day mailing presumption and the 60 calendar day filing period, the request for hearing would be due on Thursday, November 22, 2018. However, November 22, 2018, is a Federal holiday, so the filing period is extended to Friday, November 23, 2018, the next business day that the OMHA office is open for business.

Note: Weekends, holidays, and other days when businesses may be closed that occur before the last day of a filing period do not extend the filing period.

11.4.4 When is the request considered to have been filed?

A request is considered to have been filed when it is received by the office specified in the notice of reconsideration appeal instructions (for example, OMHA Central Operations for appeals of QIC reconsiderations, or SSA for appeals of SSA

reconsiderations). However, a request that is timely filed with an incorrect office satisfies the timeliness requirement (see OCPM 11.4.5).

Caution: For appeals of **QIO** reconsiderations or dismissals filed **before March 20, 2017**, the request for hearing or review is considered to have been filed on the date of the post mark, rather than the date the request was received by the office specified in the notice of reconsideration.⁸⁴

11.4.5 What do we do if the request was filed with an incorrect office or entity?

If an appellant files a request with an office or entity other than the office specified in the appeal instructions (for example, an incorrect OMHA office, or SSA, or CMS contractor office), use the date the incorrect office or entity received the request to determine timeliness.^{85, 86}

Example: A notice of reconsideration identified OMHA Central Operations as the office for filing a request for hearing. The 5 calendar day mailing presumption and 60 calendar day filing period make the request due no later than Monday, December 1, 2014. The appellant instead sends the request to the OMHA Miami Field Office, which date stamps the request as received on Friday, November 28, 2014, and forwards the request to OMHA Central Operations. OMHA Central Operations receives the request on Wednesday, December 3, 2014. Use the November 28, 2014 receipt date to determine the timeliness of the request.

Note: OMHA Central Operations issues a required acknowledgement letter to notify the appellant of the date of receipt of the request and the start of any applicable adjudication period (see [OCPM 7.2.1](#)).

⁸⁴ [42 C.F.R. § 478.42\(b\)\(3\) \(2016\)](#).

⁸⁵ [42 C.F.R. §§ 405.1014\(c\)\(2\), 423.2002\(e\), 423.2004\(a\)\(4\), 423.2014\(d\)\(2\), 478.42\(b\)\(3\)](#).

⁸⁶ The regulation at 42 C.F.R. section 405.942(b)(3) provides examples of circumstances when good cause may be found to exist when a party misses a deadline to request a redetermination, including “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.” [42 C.F.R. § 405.942\(b\)\(3\)\(vi\)](#). Although section 405.942(b)(3) is made applicable to OMHA-level appeals by [42 C.F.R. sections 405.1014\(e\)\(1\) and 423.2014\(e\)\(1\)](#), paragraph (b)(3)(vi) has limited applicability in OMHA appeals since appeals filed with an office other than the office specified in the appeal instructions are not treated as untimely pursuant to [42 C.F.R. sections 405.1014\(c\)\(2\) and 423.2014\(d\)\(2\)](#). See also [82 Fed. Reg. 4974, 5003 \(Jan. 17, 2017\)](#), [74 Fed. Reg. 65296, 65319–65320 \(Dec. 9, 2009\)](#).

11.4.6 What do we do if the request for hearing or review was untimely filed?

Requests that are untimely filed are subject to dismissal. However, appellants may request an extension of the time to file when submitting an untimely request for hearing or review. If the adjudicator finds good cause to grant the extension, the appeal proceeds. In certain circumstances, OMHA will provide another opportunity for an appellant to explain why a request for hearing or review was late if the appellant did not provide one with the request (see OCPM 11.4.6.4).

11.4.6.1 When can the time to file be extended?

The time to file may be extended when a party requests an extension and an adjudicator determines there was good cause for missing the deadline.⁸⁷

11.4.6.2 What if the appellant does not request an extension?

If the appellant did not request an extension of the time to file when submitting an untimely request for hearing or review, and:

- A circumstance listed in OCPM 11.4.6.4 **applies**, OMHA provides another opportunity for the appellant to explain why the request was filed late; or
- All circumstances listed in OCPM 11.4.6.4 do **not** apply, then the request must be dismissed (see [OCPM 17](#)).⁸⁸ The dismissal must indicate that the appellant did not provide an explanation for missing the filing deadline.

11.4.6.3 What are the requirements for a request for an extension of the time to file?

The request for an extension must:

- Be in writing (a Request for Extension of Time to File Request for Administrative Law Judge (ALJ) Hearing or Review of Dismissal (OMHA-103)⁸⁹ may be used, but is not required), unless the party is requesting an extension to request an **expedited Part D** hearing;
 - Document oral requests for an extension of time to file a request for an **expedited Part D** hearing in a Report of Contact (OMHA-101).

⁸⁷ 42 C.F.R. §§ 405.1014(e)(1), 423.2014(e)(1).

⁸⁸ 42 C.F.R. §§ 405.1052(a)(3), (b)(2), 423.2052(a)(3), (b)(2).

⁸⁹ Previously Extension Request to File a Request for an Administrative Law Judge (ALJ) Hearing (HHS-727).

- Give the reasons why the request was not filed within the required time period;
- Be filed with the request for hearing or review, or upon receipt of notice that the request may be dismissed because it was not timely filed; and
- Be filed with the office specified in the notice of reconsideration or dismissal.⁹⁰

Note: If an appellant submits a request for hearing or review with an explanation for a late filing, the request and explanation are deemed a request for an extension of time. That is, the party does not have to explicitly request an extension.

11.4.6.4 When do we provide another opportunity for an appellant to explain why a request was filed late?

If the appellant files a late request for hearing or review but: (1) does not file a request for extension; or (2) files a request for extension but does not give the reasons why the request is late, provide an opportunity to explain the reasons for the late request when:

- The appellant is an unrepresented beneficiary;
- The appellant is a beneficiary with a representative who is not a provider or supplier; or
- The adjudicator determines there is evidence in the record indicating an opportunity to explain the late request would be appropriate given the circumstances of the case.

Example: The appellant is involved in post-reconsideration discussions with the QIC, and the record indicates the appellant may not have been aware that the discussions did not extend the filing period to request a hearing.

See OCPM 11.9.1 for procedures for contacting an appellant to address a procedural defect.

⁹⁰ 42 C.F.R. §§ 405.1014(e)(2), 423.2014(e)(2)–(3).

11.4.6.5 Who can make a good cause determination for missing the filing deadline?

An **ALJ** or **attorney adjudicator** may find that:

- There is **good cause** for missing the filing deadline to request a **hearing** or **review** of a reconsideration dismissal; or
- There is **no good cause** for missing the filing deadline to request a **review** of a reconsideration dismissal.

However, only an **ALJ** may find that there is **no good cause** for missing the filing deadline to request a **hearing**.⁹¹

Note: If a request for **hearing** is assigned to an **attorney adjudicator** who does not believe there is good cause for missing the filing deadline, the appeal must be reassigned to an ALJ for a determination on whether there is good cause for missing the filing deadline to request a hearing and for adjudication of the appeal.

11.4.6.6 When does an ALJ or attorney adjudicator make a good cause determination for missing the filing deadline?

An ALJ or attorney adjudicator (*see* OCPM 11.4.6.5) must make the good cause determination before the appeal proceeds past the procedural review process (for example, before a hearing is scheduled). This helps ensure that procedural matters and untimely appeals are addressed as early in the process as possible and that the government and the parties do not invest unnecessary time and expense in appeals subject to a procedural dismissal.

11.4.6.7 What does an ALJ or attorney adjudicator consider in determining whether there is good cause for missing the filing deadline?

In determining whether there is good cause for missing the filing deadline, an ALJ or attorney adjudicator considers:

- The circumstances that kept the party from making the request on time;
- Whether a contractor's, SSA's, or OMHA's action(s) misled the party; and

⁹¹ 42 C.F.R. §§ 405.1014(e)(3), 423.2014(e)(4).

- Whether 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.⁹²

Examples of when good cause for missing the filing deadline may be found include:

- 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 or review of a dismissal; or
- The party did not receive notice of the reconsideration or dismissal of the request for a reconsideration.

Note: A request for hearing or review sent by a party to a government agency in good faith within the time limit, but not received by the appropriate entity until after the time period to file a request expired, is not considered untimely and does not require a finding of good cause.⁹³

11.4.6.8 What happens when an adjudicator finds good cause for missing a filing deadline?

If an ALJ or attorney adjudicator finds that there is good cause for missing the filing deadline, the filing period is extended to the date the request for hearing or review was filed.⁹⁴

The date the ALJ or attorney adjudicator finds good cause for missing the filing deadline **must be documented** in an order (for example, an interlocutory order on the request for an extension, or an order dismissing the request on other grounds) or in the decision.

⁹² 42 C.F.R. §§ 405.1014(e)(3) (referencing § 405.942(b)(2)), 423.2014(e)(4) (referencing § 405.942(b)(2)).

⁹³ 42 C.F.R. §§ 405.1014(e)(3) (referencing § 405.942(b)(3)), 423.2014(e)(4) (referencing § 405.942(b)(3)); see note 86.

⁹⁴ 42 C.F.R. §§ 405.1014(e)(3), 423.2014(e)(4).

Note: Any applicable adjudication period begins on the date the extension request is granted (that is, the date that good cause for missing the deadline is found).⁹⁵

A determination that there is good cause for missing the filing deadline is **not subject to further review.**

Note: If an attorney adjudicator finds there is good cause for missing the filing deadline, and the appeal is later transferred to an ALJ for other reasons, the ALJ may not review or otherwise reconsider the attorney adjudicator's good cause determination for missing the filing deadline.⁹⁶

11.4.6.9 What happens when an adjudicator finds there is no good cause for missing a filing deadline?

If an ALJ finds there is no good cause for missing the filing deadline to request a hearing, or an ALJ or attorney adjudicator finds there is no good cause for missing the filing deadline to request a review, the request must be dismissed.⁹⁷ See [OCPM 17](#) for more information on dismissals.

- If the appellant did not provide an explanation for missing the filing deadline, the dismissal must include a summary statement relating this fact.

Example: "The appellant has not provided any explanation for its late filing. Therefore, I find that there is no good cause to extend the period for timely filing in this case."

Note: See OCPM 11.4.6.4 for situations when an appellant who has not provided an explanation for the late filing with the request for hearing or review will be given another opportunity to do so.

- If the appellant provided an explanation for missing the filing deadline, the dismissal must explain why the reason does not constitute good cause.

Note: **Only an **ALJ** may find that there is no good cause for missing the filing deadline to request a **hearing**. Either an **ALJ** or an **attorney adjudicator****

⁹⁵ 42 C.F.R. §§ 405.1014(e)(4), 423.2014(e)(5).

⁹⁶ 42 C.F.R. §§ 405.1014(e)(5), 423.2014(e)(6).

⁹⁷ 42 C.F.R. §§ 405.1052(a)(3), (b)(2), 423.2052(a)(3), (b)(2).

may find that there is no good cause for missing the filing deadline to request a **review**.⁹⁸

⁹⁸ 42 C.F.R. §§ 405.1014(e)(3), 423.2014(e)(3).

11.5 Complete requests

(Issued: 05-24-19, Effective: 05-24-19)

11.5.1 What is a complete request?

A complete request for hearing or review is a request that:

- Is in writing, *except* for a request for an **expedited Part D** hearing; and
- Provides all information required by regulation.⁹⁹

If a request is not complete, the request is subject to dismissal, but the party must be provided with an opportunity to cure the defect (*see* OCPM 11.9).

Note: The form for requesting an ALJ hearing or review of a dismissal (OMHA-100), asks for more information than is required by regulation (for example, the appellant’s email address). The additional information is to assist with processing the case but is not required for a complete request, and a request may not be dismissed because it does not provide the additional information.

11.5.2 What constitutes a “writing”?

Any form of writing is acceptable.

Note: With the exception of the **expedited Part D** hearing request fax option, OMHA does not encourage faxing requests and does not maintain a dedicated fax line for requests. However, if a request for hearing or review is received via fax, it **does** qualify as a written request.

11.5.3 What documents does an adjudicator consider in determining whether a request is complete?

An adjudicator considers all documents submitted with the request when determining whether the request provides the information required by regulation.¹⁰⁰

⁹⁹ 42 C.F.R. §§ 405.1002(a)(1), 405.1004(a)(1), 405.1014(a), 422.602(a), 423.2002(a)(1), 423.2004(a)(1), 423.2014(a) (*but see* 423.2014(b) allowing oral requests for expedited hearings), 478.42(a).

¹⁰⁰ 42 C.F.R. §§ 405.1014(b)(2), 423.2014(c)(2).

Example: If an appellant submits a copy of the appealed reconsideration with the request for hearing, the adjudicator considers the information contained in the reconsideration in assessing whether the required information was provided.

11.5.4 What information is necessary for a complete request?

There are no content requirements prescribed by regulation for **requests to escalate** an appeal from a QIC to OMHA, for appeals of a **Part C** reconsideration or dismissal, or for appeals of an **SSA** reconsideration.

For **all other appeals**, the following information is required by regulation for the request for hearing to be complete:

Element	Part A / Part B QIC, QIO ¹⁰¹	Part D IRE ¹⁰²
Beneficiary: <ul style="list-style-type: none"> • Name • Address • Medicare number (HICN or MBI) 	Required	
Beneficiary: <ul style="list-style-type: none"> • Telephone number 	Required for requests filed on or after March 20, 2017 , if the beneficiary is the appellant	Required
Appellant: <ul style="list-style-type: none"> • Name • Address 	Required, if the appellant is <u>not</u> the beneficiary	Not applicable
Appellant <ul style="list-style-type: none"> • Telephone number 	Required for requests filed on or after March 20, 2017	Not applicable

¹⁰¹ 42 C.F.R. § 405.1014(a); 405.1014(a) (2016)

¹⁰² 42 C.F.R. § 423.2014(a); 423.2014(a) (2016).

Element	Part A / Part B QIC, QIO ¹⁰¹	Part D IRE ¹⁰²
Representative: <ul style="list-style-type: none"> • Name • Address 	Required, if there is one	
Representative: <ul style="list-style-type: none"> • Telephone number 	Required, if there is one, for requests filed on or after March 20, 2017	Required, if there is one
Case / appeal / control number of appealed matter (for example, the “Medicare Appeal number” listed on a QIC reconsideration or a QIO “claim key.”)	Required, if there is one (Some QIO reconsiderations may not have one.)	Required
Item, service, or drug information	Dates of service for disputed items/services (see note) <i>or</i> Date of discharge	Name of drug(s) in dispute
Plan name	Not applicable	Part D plan sponsor name
Reason appellant disagrees with the reconsideration or other determination being appealed	Required (Any reason for disagreement satisfies the requirement—for example, “I disagree with the reconsideration because the services were necessary.”)	

Element	Part A / Part B QIC, QIO ¹⁰¹	Part D IRE ¹⁰²
Statement that additional evidence will be submitted and date it will be submitted ¹⁰³	Not required	
Statement that an expedited hearing is requested ¹⁰⁴	Not applicable	Required if requesting expedited hearing

The following special rules apply to **appeals of statistical samples** when the appellant disagrees with how a statistical sample and/or extrapolation was conducted:

- Appellants must identify the required information above for each sample unit appealed (for example, the beneficiary, date of service, reason for disagreement, and if separately adjudicated by a QIC, the Medicare appeal number for each appealed sample unit); and
- Appellants must provide the reasons why they disagree with how the statistical sample and/or extrapolation process was conducted.¹⁰⁵

Note: If a request only specifies some of the beneficiaries or claims from the reconsideration, treat the request as only requesting a hearing or review for the specified beneficiaries or claims. However, if the request is not clear on its face, contact the appellant for clarification.

11.5.5 What do we do if the request is incomplete?

The appellant must be notified that the request is missing information required by regulation and provided with an opportunity to cure the defect. The notice must specify which required elements are missing. If an adjudication time frame applies, it does not begin until the request is complete (see [OCPM 7.2](#)).¹⁰⁶

¹⁰³ Not considered in determining whether a request is complete.

¹⁰⁴ Not considered in determining whether a request is complete.

¹⁰⁵ 42 C.F.R. § 405.1014(a)(3).

¹⁰⁶ 42 C.F.R. § 405.1014(b)(1).

See OCPM 11.9.1 for procedures for contacting an appellant to address a procedural defect.

11.6 Copy requirements

(Issued: 05-24-19, Effective: 05-24-19)

11.6.1 What are the copy requirements, and when do they apply?

For appeals of **Part A** and **Part B** QIC and QIO reconsiderations and dismissals, the appellant must send a copy of the request for hearing or review to the other parties to the claim who were sent a copy of the notice of the reconsideration or dismissal being appealed.¹⁰⁷ The copy requirement may not be waived (for example, by a provider-appellant asserting it will not collect from the beneficiary).

If the appellant does not send the required copies, then the request is subject to dismissal, however, *the party must be contacted and provided with an opportunity to cure the defect* (or, for unrepresented beneficiary appellants, the copy is sent by OMHA on the beneficiary's behalf). See OCPM 11.9 for information on how to proceed.

11.6.2 When does the copy requirement not apply?

This copy requirement does not apply:

- When a **QIC did not send a notice** of the reconsideration or dismissal to the other parties (for example, if a QIC elects not to send a notice to beneficiaries in an overpayment case involving multiple beneficiaries who have no liability¹⁰⁸);
- To **escalations** of requests for a Part A or Part B QIC reconsideration, because an appellant is only responsible for sending a request for escalation to the QIC;¹⁰⁹
- To requests appealing a **Part C IRE or QIO reconsidered determination or dismissal**, because [42 C.F.R. section 422.602](#) addresses requests filed under part 422 and does not require a copy to be sent other parties;
- To requests appealing a **Part D IRE reconsideration or dismissal**, because [42 C.F.R. section 423.2014](#) addresses requests under part 423 and does not require a copy because the enrollee is the only party; and

¹⁰⁷ [42 C.F.R. § 405.1014\(d\)\(1\)](#). For requests filed before March 20, 2017, [section 405.1014\(b\)\(2\) \(2016\)](#) did not limit the recipients to the parties who were sent a copy of the notice of reconsideration or dismissal; however, for consistency with notice and copy provisions at other levels of the appeals process, OMHA applied the rule to that affect.

¹⁰⁸ [42 C.F.R. § 405.976\(a\)\(2\)](#).

¹⁰⁹ [42 C.F.R. § 405.970\(d\)](#).

- To requests appealing an **SSA reconsideration**, because the beneficiary is the only party.

11.6.3 To whom does the appellant send copies?

The appellant must send a copy of its request to any other party who was sent a notice of the Part A or Part B QIC or QIO reconsideration or dismissal being appealed. If the other party is represented, the copy is sent to the representative.

Note: The notice of reconsideration or dismissal may name a specific party or generically indicate multiple parties (for example, "Cc: Beneficiaries"). If the notice generically indicates multiple parties, the appellant may rely on the reconsideration or dismissal to identify the appropriate parties to whom to send a copy of the request (for example, the beneficiaries whose claims were reconsidered).

Note: If a QIC elects not to send a notice to the beneficiaries in an overpayment appeal involving multiple beneficiaries who are not liable, the appellant is not required to send a copy of the request for hearing to the beneficiaries.

Note: If a QIC or QIO also sends notice to another CMS contractor, the appellant is not required to send a copy of the request to the CMS contractor because the CMS contractor is not a party to the appeal.

11.6.4 How does an appellant demonstrate that the copy requirement was met?

The record must contain evidence that the appellant sent a copy of the request to the other parties. The appellant may take any of the actions listed below to satisfy the requirement, provided documentation of the action is in the record. An appellant may provide additional evidence to support that it sent a copy of the request to the other parties, but an appellant may not be required to do so unless the record suggests the parties were not actually sent a copy or were not sent a copy in accordance with the regulations.

Note: Proof of delivery (in other words, evidence of receipt by the other party) is not required, but may, at the appellant's discretion, be used as evidence that the request was sent.

Requests filed on or after March 20, 2017

- Completion of the certification in the appropriate section of the standard Request for Administrative Law Judge (ALJ) Hearing or Review of Dismissal (OMHA-100), indicating that the required copies were sent;

Note: Prior versions of the standard form for requesting a hearing or review of a dismissal (listed below) do not contain sufficient documentation to satisfy the copy requirement for requests filed on or after March 20, 2017:

- Request for Medicare Hearing by an Administrative Law Judge (CMS-20034 A/B)
- Request for Medicare Hearing by an Administrative Law Judge (CMS-5011 A/B)
- Request for Administrative Law Judge (ALJ) to Review Dismissal by the Qualified Independent Contractor (HHS-725)

If a party submitted a request for hearing or review on or after March 20, 2017, using one of these older forms, evidence that a copy of the request was sent to the other parties must be satisfied by one of the remaining methods listed below.

- An indication in the request itself that the appellant sent the required copies (for example, in a copy or “cc” line), including the name and address of any recipient to whom a copy was sent;
- An affidavit or certificate of service that identifies the name and address of the recipient, and what was sent to the recipient; or
- A mailing or shipping receipt that identifies the name and address of the recipient, and what was sent to the recipient.¹¹⁰

Requests filed before March 20, 2017

- Completion of the checkbox in the standard Request for Medicare Hearing by an Administrative Law Judge (CMS-20034 A/B), indicating that the required copies were sent;

¹¹⁰ 42 C.F.R. § 405.1014(d)(2).

Note: The standard Request for Administrative Law Judge (ALJ) Hearing or Review of Dismissal (OMHA-100), released on January 24, 2017, may also be used.

However, the following prior versions of the standard form for requesting a hearing or review of a dismissal do not contain a section certifying that the appellant sent the required copies. Therefore, completion of these forms alone would not satisfy the requirement:

- Request for Medicare Hearing by an Administrative Law Judge (CMS-5011 A/B)
- Request for Administrative Law Judge (ALJ) to Review Dismissal by the Qualified Independent Contractor (HHS-725)

- A written statement by the appellant submitted with the request, indicating that a copy of the request was sent to the other parties; or
- A request for hearing or review in a letter format that indicates the other parties were copied, such as listing the other parties on “cc” lines.

11.6.5 What documents must the appellant send to the other parties with the copy of the request?

The appellant must send a copy of all of the documents that together make a complete request.

- If all of the information is contained in a single document, such as a complete OMHA-100, a copy of the form is sufficient.
- If the information is contained in multiple documents, the appellant must include a copy of all of the relevant documents.

Example: A cover letter requesting a hearing is submitted with a copy of the QIC reconsideration, and the reconsideration is necessary for a complete request because the cover letter does not identify the dates of service for the appealed claims. The appellant must therefore send a copy of the letter *and* reconsideration to the other parties.

The appellant is not required to send copies of **evidence** submitted with the request to the other parties. When an appellant submits a brief or position paper, or evidence with a request—assuming the brief or position paper, or evidence, is not a necessary

component to consider the request complete—the appellant may send copies of the materials with the copy of the request, *or* briefly describe the evidence pertinent to the party, indicate the other materials are available upon request, and provide contact information for the other parties to obtain the materials.

11.6.6 How can an appellant protect PII / PHI?

The appellant may redact names, Medicare numbers (HICNs or MBIs), and other personal identifiers in the same manner as OMHA would redact such information.

Example: OMHA generally redacts the names of beneficiaries to the first initial and last name, and redacts Medicare numbers to the last four numeric digits of a HICN and any alphabetic or alphanumeric suffix, or the last five alphanumeric digits of an MBI. An appellant may do the same when sending a copy of the request.

11.6.7 What do we do if the record does not reflect that the required copies were sent to the other parties?

If the appellant is an unrepresented beneficiary

Send a copy of the beneficiary’s request to the other parties who were sent a copy of the QIC’s or QIO’s reconsideration or dismissal, using Notice of Request for Hearing or Review Filed by an Unrepresented Beneficiary (OMHA-310).¹¹¹

All other appellants

The appellant must be notified that the record does not reflect that the required copies were sent to the other parties, and must be provided with an opportunity to cure the defect. If an adjudication time frame applies, it does not begin until OMHA receives evidence that the request was sent to the appropriate parties (*see* [OCPM 7.2](#)).¹¹²

See OCPM 11.9.1 for procedures for contacting an appellant to address a procedural defect.

¹¹¹ 42 C.F.R. § 405.1052(a)(7), (b)(4).

¹¹² 42 C.F.R. §§ 405.1014(d)(3).

11.7 Part D expedited requests

(Issued: 05-24-19, Effective: 05-24-19)

11.7.1 What is the general requirement?

If an enrollee requests an **expedited Part D** hearing, an ALJ or attorney adjudicator must grant or deny the request for the expedited hearing (or proceedings if no hearing is necessary).

- An adjudicator may grant a request that meets the requirements for an expedited hearing (see OCPM 11.7.2).
- An adjudicator must make the determination to grant or deny the expedited hearing within five calendar days of receiving the request (see OCPM 11.7.4).
- OMHA must issue oral and written notice to the enrollee of the determination to grant or deny the expedited hearing (see OCPM 11.7.5).

11.7.2 When does an adjudicator grant a request for an expedited hearing?

An adjudicator grants an expedited hearing if:

- The appeal involves an issue specified in [42 C.F.R. section 423.566\(b\)](#) but is not solely a request for payment of Part D drugs already furnished; and
 - [Section 423.566\(b\)](#) describes actions that are coverage determinations (see OCPM 11.1.1).
- The enrollee's prescribing physician or other prescriber indicates, *or* an ALJ or attorney adjudicator determines, that applying the standard time frame for making a decision may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.¹¹³
 - A physician or other prescriber's statement indicating that applying the standard time frame for making a decision may seriously jeopardize the enrollee's life, health, or ability to regain maximum function is not subject to review by the adjudicator.

An ALJ or attorney adjudicator may consider the standard met if a lower-level adjudicator granted a request for an expedited proceeding.¹¹⁴

¹¹³ 42 C.F.R. § 423.2016(b)(1).

¹¹⁴ 42 C.F.R. § 423.2016(b)(1).

11.7.3 What do we do if the request does not provide the information necessary to make the determination to grant or deny the expedited hearing?

Contact the enrollee (or, if represented, the representative) for information needed to determine whether to grant or deny the expedited hearing. Document any oral conversations in a Report of Contact (OMHA-101).

Example: If it is unclear whether the enrollee has the disputed drug, contacting the enrollee (or representative) would be appropriate.

Example: If an adjudicator determines that additional information is needed to determine whether applying the standard time frame for making a decision may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, the adjudicator, or a designee (if assigned to an ALJ), may contact the enrollee (or representative).

11.7.4 How long do we have to grant or deny an expedited hearing request?

A determination to grant or deny a request for an expedited hearing must be made within **five calendar days** of OMHA receiving the request for an expedited hearing.

Note: The five calendar day time frame to grant or deny the expedited hearing is independent of the adjudication time frame.¹¹⁵ An incomplete request for hearing does not extend the five calendar days.

11.7.5 How do we provide notice of granting or denying an expedited hearing?

Provide oral *and* written notice.

Oral notice of the determination to grant or deny an expedited hearing must be given to the enrollee within the five calendar day period.¹¹⁶ If the expedited hearing is denied, the oral notice must include an explanation that the adjudicator will process the enrollee's request using the 90 calendar day time frame for non-expedited appeals.¹¹⁷

- The oral notice must be documented in a Report of Contact (OMHA-101).

¹¹⁵ Compare 42 C.F.R. § 423.2016(b)(2)(i), (b)(3)(i), with § 423.2016(a)(1) and (b)(5).

¹¹⁶ 42 C.F.R. § 423.2016(b)(2)(ii), (b)(3)(ii).

¹¹⁷ 42 C.F.R. § 423.2016(b)(3)(ii).

Written notice must follow the oral notice and also be sent to the Part D plan sponsor:

- If the expedited hearing is **granted**, the written notice is generally provided as part of the Notice of Expedited Part D Hearing (OMHA-624).¹¹⁸
- If the expedited hearing is denied, send an Order Denying Request to Expedite (OMHA-616) within three calendar days after the oral notice is provided.¹¹⁹

11.7.6 What happens to an appeal if an adjudicator grants an expedited hearing?

If an adjudicator grants an expedited hearing, OMHA issues a disposition as quickly as the enrollee's health condition requires, but no later than the end of the 10 calendar day period beginning on the date that OMHA received the request for hearing (or if the request was not timely filed, the date the adjudicator granted an extension of the filing deadline), unless the adjudication time frame is extended (*see* [OCPM 7.2](#)).¹²⁰

Note: Expedited proceedings and shortened time frames for notices and responses will operate to facilitate the 10 calendar day adjudication time frame.

11.7.7 What happens to an appeal if an adjudicator denies an expedited hearing?

If an adjudicator denies an expedited hearing, OMHA processes the request for hearing using the standard 90 calendar day adjudication time frame.¹²¹

11.7.8 Can the determination to grant or deny an expedited hearing be appealed?

No. The determination to grant or deny an expedited hearing may not be appealed.¹²²

¹¹⁸ 42 C.F.R. § 423.2016(b)(2)(iii).

¹¹⁹ 42 C.F.R. § 423.2016(b)(3)(iii).

¹²⁰ 42 C.F.R. § 423.2016(b)(5).

¹²¹ 42 C.F.R. § 423.2016(b)(3)(ii).

¹²² 42 C.F.R. § 423.2016(b)(4).

11.8 Other procedural matters

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11.8.1 When do we have to address other procedural matters?

Additional procedural matters that may result in a dismissal of a request are uncommon. OMHA adjudicators are not expected to research these uncommon procedural matters unless the record indicates there may be an issue, or an individual employee working on an appeal has knowledge that there may be an issue. This section contains details on some of the other procedural matters that may arise—consult a local senior or supervisory attorney if you encounter a procedural matter not addressed in this chapter.

If other procedural issues are identified, such as a suspected excluded individual or entity (*see* OCPM 11.8.2), an opportunity for the appellant to explain the issue must be provided before proceeding to dismissal. The procedural issue must be summarized for the appellant in a manner that the appellant can understand and respond to, and any related documentation (for example, a screen print of the OIG exclusion database results) must be provided.

11.8.2 Is the appellant an excluded provider or supplier?

The HHS OIG has the authority to exclude individuals and entities from the Medicare program. An excluded individual or entity generally may not furnish or prescribe items or services during any period in which the individual or entity is excluded from the program, and may not be employed by another to do so.

CMS contractors and plans generally screen exclusions out of the appeal process at the initial levels of appeal. However, if the record or other information suggests that an individual or entity was, or may have been, excluded on the date of service, the OIG exclusion database must be checked.

The OIG exclusions database is accessible at <https://oig.hhs.gov/exclusions/index.asp>.

Caution: There have been instances in which an appellant has a name that is similar to an excluded individual's or entity's name. Additional information may be relevant to consider before concluding an individual or entity is excluded, such as the precise name, and the state or locality of the business.

11.8.3 Was the provider or supplier enrolled in the program at the time of service?

A provider or supplier must have been enrolled in the Medicare program at the time items or services were furnished to a Medicare beneficiary in order to submit claims for those items or services and appeal any denials of those claims. On occasion, a provider's or supplier's enrollment may be revoked, and, in some instances, the revocation may have retroactive effect.

Note: ALJs within the DAB's Civil Remedies Division adjudicate provider and supplier enrollment appeals. However, appeals of claims denied because the provider or supplier was not enrolled in Medicare, or the enrollment was retroactively revoked, may proceed concurrently with OMHA.

In these instances, the issue for the claim appeal is limited to what the provider's or supplier's status was at the time of service, based on the status as of the most recent determination by CMS or, if appealed, the DAB. OMHA ALJs do not have delegated authority to address the provider's or supplier's enrollment status. If the CMS enrollment determination is reversed by an ALJ in the DAB Civil Remedies Division or the DAB itself, any claims denied on the basis that the provider or supplier was not enrolled in Medicare at the time of service will be paid, unless there are other reasons the claims should be denied. The claim appeals before OMHA are not held or stayed pending the outcome of enrollment appeals.

11.8.4 Is the provider or supplier in bankruptcy?

If a party has entered bankruptcy proceedings, the claim appeals remain pending because the matter before OMHA is related to whether Medicare coverage and payment requirements were met, rather than whether there is a debt or obligation. The provider or supplier may continue to pursue the claim appeals, *unless* the Bankruptcy Trustee enters the proceedings on behalf of the bankruptcy estate.

11.8.5 Is the provider or supplier no longer in business?

If it is determined that a party is no longer in business based on mail or phone contacts to the last known address, and no forwarding information or a new contact (such as a successor in interest) is provided, the request may be subject to dismissal for **abandonment** if OMHA attempts to schedule the hearing and is unable to contact the appellant after making reasonable efforts to do so (see [OCPM 17.1.9](#)) or for **failure to appear** at a hearing if a notice of hearing was sent to the last known address, the

appellant (or appellant's representative) does not respond to the notice of hearing, fails to appear at the hearing, and fails to respond to an Order to Show Cause for Failure to Appear (OMHA-164) (see [OCPM 17.1.4](#)).

11.9 Addressing procedural defects

(Issued: 05-24-19, Effective: 05-24-19)

11.9.1 What is the general process for contacting an appellant to address a procedural defect?

When an opportunity to address a procedural defect is available, send a Notice of Filing Defect (OMHA-125) to the appellant and/or the appellant's representative (depending on the defect and whether the appeal involves an MSP recovery from a beneficiary (see OCPM 11.9.3)). The notice must identify **all** of the procedural defects for the appeal.

- If the defects are **cured** (that is, the defects no longer exist after the response and information are taken into consideration), the appeal proceeds in the adjudication process.
- If the defects are **not cured**, the request is subject to dismissal (see [OCPM 17](#)).

Special rule for Part D expedited appeals

Oral notice of the procedural defects and oral resolution of those defects is permitted for Part D expedited appeals. In such case the discussion with the enrollee or representative must be documented in a Report of Contact (OMHA-101).

If the defects are not resolved orally, issue a Notice of Filing Defect (OMHA-125) for any outstanding defects.

11.9.2 What happens with the appeal while procedural defects are being addressed?

No further action is taken on the appeal until the procedural defects are resolved.

Note: The defects may affect any applicable adjudication time frame. See [OCPM 7.2](#) for general information on events that delay the start of, or extend, adjudication time frames.

Special rule for Part D expedited appeals.

Further actions may be taken on the appeal while procedural defects are being addressed, including determinations to grant an expedited hearing, and scheduling and conducting an expedited hearing. However, a decision cannot be issued until the procedural defects are resolved because the defect may implicate the jurisdictional authority to issue a decision.

11.9.3 What is the process for issuing a notice of filing defect?

The Notice of Filing Defect (OMHA-125) is sent to the appellant **or** if represented, the representative, except that:

- If the appeal involves an **MSP** recovery from a beneficiary and the beneficiary is represented, the notice is sent to **both** the beneficiary and the representative.
- If there is a procedural issue with a representative appointment or authorizing document, the notice is sent to the appellant and a courtesy copy may be sent to the purported representative with any necessary redactions (see [OCPM 5.2.7](#)).

The notice provides 20 calendar days from receipt of the notice to cure the defects. Receipt is presumed to be five calendar days after the notice is issued, *unless* there is evidence to the contrary.

The notice informs the appellant that the request is subject to dismissal if the procedural defects are not cured within the stated time period.

11.9.4 What happens after the appellant responds to a notice of filing defect?

Upon receipt, the response and any accompanying information is assessed to determine whether the defects detailed in the notice have been cured. An ALJ or attorney adjudicator makes the final determination on whether the identified defects have been cured.

11.9.4.1 What happens when the defects are cured?

If the defects are cured, the appeal proceeds.

Note: Certain defects may impact any applicable adjudication time frame. See [OCPM 7.2](#) for general information on events that delay the start of, or extend, adjudication time frames.

11.9.4.2 How do we proceed when the defects are not cured?

If the defects are not cured, the request is dismissed (see [OCPM 17](#)).

11.9.5 What do we do if the appellant does not respond to the notice of filing defect?

The request is dismissed (*see* [OCPM 17](#)), *unless* the only defect was an invalid authorization or appointment of representative and the request was filed by the party (*see* [OCPM 5.2.8](#)).

Revision history

Date	Description	Sections/subsections updated
12/09/2021	Revised to update the minimum amount in controversy to reflect the ten most recent calendar years; replace inoperative hyperlinks.	11.3.2; 11.4.5
07/12/2019	Revised to replace references to OMHA Program Evaluation and Policy Division with references to Appeals Policy and Operations Division; replace footnote citation to Federal Register with citation to revised 42 C.F.R. section 405.1006(d)(4).	11.3.4; 11.3.6.3
05/24/2019	Initial Release	N/A

If the table above indicates there are prior versions of this chapter, click [here](#) to view them.