(d) The amount in controversy is $100 or more.

[40 FR 1025, Jan. 6, 1975. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 62 FR 25855, May 12, 1997]

§ 405.722 Time and place of filing request for a hearing.

The request for a hearing shall be made in writing and filed at an office of the SSA or the CMS or with a ALJ, or, in the case of a qualified railroad retirement beneficiary, at an office of the Railroad Retirement Board. Such request must be filed within 60 days after the date of receipt of notice of the reconsidered determination by such individual, except where the time is extended as provided in 20 CFR 404.933(c). For purposes of this section, the date of receipt of notice of the reconsidered determination shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary.

[45 FR 73933, Nov. 7, 1980, as amended at 62 FR 25855, May 12, 1997]

§ 405.724 Departmental Appeals Board (DAB) review.

Regulations beginning at 20 CFR 404.967 regarding SSA Appeals Council Review are also applicable to DAB review of matters addressed by this subpart.

[62 FR 25852, May 12, 1997]

§ 405.730 Court review.

(a) To the extent authorized by sections 1869, 1876(c)(5)(B), and 1879(d) of the Act, a party to a Departmental Appeals Board (DAB) decision or an ALJ decision if the DAB does not review the ALJ decision, may obtain a court review if the amount remaining in controversy is $1,000 or more. A party may obtain court review by filing a civil action in a district court of the United States in accordance with the provisions of section 205(g) of the Act. The filing procedure is set forth at 20 CFR 422.210.

(b) A party to a reconsidered determination or an ALJ hearing decision may obtain a court review if the amount in controversy is $1,000 or more, and he or she requests and meets the conditions for the expedited appeals process set forth in § 405.718.

[62 FR 25852, May 12, 1997]

§ 405.732 Review of a national coverage determination (NCD).

(a) *General rule.* (1) An NCD is a determination by the Secretary for whether or not a particular item or service is covered nationally under title XVIII of the Act.

(2) An NCD does not include a determination of what code, if any, is assigned to a particular item or service covered under title XVIII or a determination for the amount of payment made for a particular item or service.

(3) NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act.

(4) An NCD is binding on all Medicare carriers, fiscal intermediaries, QIOs, HMOs, CMPs, HCPPs, the Medicare Appeals Council, and ALJs.

(b) *Review by ALJ.* (1) An ALJ may not disregard, set aside, or otherwise review an NCD.

(2) An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD has been applied correctly to the claim.

(c) *Review by Court.* For initial determinations and NCD challenges under section 1862(a)(1) of the Act, arising before October 1, 2002, a court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case has been remanded to the Secretary to supplement the record regarding the NCD. In these cases, the court may not invalidate an NCD except upon review of the supplemental record.

[68 FR 63715, Nov. 7, 2003]

§ 405.740 Principles for determining the amount in controversy.

(a) *Individual appellants.* For the purpose of determining whether an individual appellant meets the minimum amount in controversy needed for a hearing ($100), the following rules apply:

(1) The amount in controversy is computed as the actual amount

charged the individual for the items and services in question, less any amount for which payment has been made by the intermediary and less any deductible and coinsurance amounts applicable in the particular case.

(2) A single beneficiary may aggregate claims from two or more providers to meet the $100 hearing threshold and a single provider may aggregate claims for services provided to one or more beneficiaries to meet the $100 hearing threshold.

(3) In either of the circumstances specified in paragraph (a)(2) of this section, two or more claims may be aggregated by an individual appellant only if the claims have previously been reconsidered and a request for hearing has been made within 60 days after receipt of the reconsideration determination(s).

(4) When requesting a hearing, the appellant must specify in his or her appeal request the specific claims to be aggregated.

(b) *Two or more appellants.* As specified below, under section 1869(b)(2) of the Act, two or more appellants may aggregate their claims together to meet the minimum amount in controversy needed for a hearing ($100). The right to aggregate under this statutory provision applies to claims for items and services furnished on or after January 1, 1987.

(1) The aggregate amount in controversy is computed as the actual amount charged the individual(s) for the items and services in question, less any amount for which payment has been made by the intermediary and less any deductible and coinsurance amounts applicable in the particular case.

(2) In determining the amount in controversy, two or more appellants may aggregate their claims together under the following circumstances:

(i) Two or more beneficiaries may combine claims representing services from the same or different provider(s) if the claims involve common issues of law and fact;

(ii) Two or more providers may combine their claims if the claims involve the delivery of similar or related services to the same beneficiary; or

(iii) Two or more providers may combine their claims if the claims involve common issues of law and fact with respect to services furnished to two or more beneficiaries.

(iv) In any of the circumstances specified in paragraphs (b)(2)(i) through (b)(2)(iii) of this section, the claims may be aggregated only if the claims have previously been reconsidered and a request for hearing has been made within 60 days after receipt of the reconsideration determination(s). Moreover, in the request for hearing, the appellants must specify the claims that they seek to aggregate.

(c) The determination as to whether the amount in controversy is $100 or more is made by the administrative law judge (ALJ).

(d) In determining the amount in controversy under paragraph (b) of this section, the ALJ also makes the determination as to what constitutes ''similar or related services'' or ''common issues of law and fact.''

(e) When a civil action is filed by either an individual appellant or two or more appellants, the Secretary may assert that the aggregation principles contained in this subpart may be applied to determine the amount in controversy for judicial review ($1000).

(f) Notwithstanding the provisions of paragraphs (a)(1) and (b)(1) of this section, when payment is made for certain excluded services under § 411.400 of this chapter or the liability of the beneficiary for those services is limited under § 411.402 of this chapter, the amount in controversy is computed as the amount that would have been charged the beneficiary for the items or services in question, less any deductible and coinsurance amounts applicable in the particular case, had such expenses not been paid pursuant to § 411.400 of this chapter or had such liability not been limited pursuant to § 411.402 of this chapter.

(g) Under this subpart, an appellant may not combine part A and part B claims together to meet the requisite amount in controversy for a hearing. HMO, CMP and HCPP appellants under part 417 of this chapter may combine part A and part B claims together to

meet the requisite amounts in controversy for a hearing.

[59 FR 12181, Mar. 16, 1994]

§ 405.745 Amount in controversy ascertained after reconsideration.

For the purpose of determining whether a party to a reconsidered determination is entitled to a hearing, the amount in controversey after the reconsideration action rather than the amount in controversy initially at issue shall be controlling.

[40 FR 1026, Jan. 6, 1975. Redesignated at 42 FR 52826, Sept. 30, 1977]

§ 405.747 Dismissal of request for hearing; amount in controversy less than $100.

The ALJ shall, without holding a hearing, dismiss the request for hearing if the request for hearing plainly shows that less than $100 is in controversy. If a hearing is held and the ALJ finds that the amount in controversy is less than $100, the ALJ shall dismiss the request for hearing and will not rule on the substantive issues involved in the appeal.

[37 FR 5814, Mar. 23, 1972. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 62 FR 25855, May 12, 1997]

§ 405.750 Time period for reopening initial, revised, or reconsidered determinations and decisions or revised decisions of an ALJ or the Departmental Appeals Board (DAB); binding effect of determination and decisions.

(a) *Reopenings concerning applications and entitlement.* A determination, or decision, or revised determination or decision made by the SSA concerning any matter under § 405.704(a), may be reopened and revised under 20 CFR 404.988 (Conditions for reopening).

(b) *Reopenings concerning a request for payment.* An initial, revised, or reconsidered determination of CMS, or a decision or revised decision of an ALJ or of the DAB, with respect to an individual's right concerning a request for payment under Medicare Part A, which is otherwise binding under 20 CFR 404.955 or 404.981 and § 405.708 or § 405.717 of this subpart may be reopened:

(1) Within 12 months from the date of the notice of the initial or reconsidered determination to the party to such determination;

(2) After such 12-month period, but within 4 years after the date of the notice of the initial determination to the individual, upon establishment of good cause for reopening such determination or decision (see 20 CFR 404.988(b) and 404.989); or

(3) At any time, when:

(i) Such initial, revised, or reconsidered determination or such decision or revised decision is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting clerical error or error on the face of the evidence on which such determination or decision was based; or

(ii) Such initial, revised, or reconsidered determination or such decision or revised decision was procured by fraud or similar fault of the beneficiary or some other person.

[45 FR 73933, Nov. 7, 1980, as amended at 61 FR 32348, June 24, 1996; 62 FR 25853, 25855, May 12, 1997]

§ 405.753 Appeal of a categorization of a device.

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

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

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

[60 FR 48424, Sept. 19, 1995]

Subpart H—Appeals Under the Medicare Part B Program

AUTHORITY: Secs. 1102, 1842(b)(3)(C), 1869(b), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395u(b)(3)(C), 1395ff(b), and 1395hh).