

coverage or payment issues related to the appealed claim and no redetermination of the claim was made (if a redetermination was required under this subpart) or the request for redetermination was dismissed, the reconsideration will be remanded to the QIC, or its successor to re-adjudicate the request for reconsideration.

(c) *Requested remand*—(1) *Request contents and timing*. At any time prior to an ALJ or attorney adjudicator issuing a decision or dismissal, the appellant and CMS or one of its contractors may jointly request a remand of the appeal to the entity that conducted the reconsideration. The request must include the reasons why the appeal should be remanded and indicate whether remanding the case will likely resolve the matter in dispute.

(2) *Granting the request*. An ALJ or attorney adjudicator may grant the request and issue a remand if he or she determines that remanding the case will likely resolve the matter in dispute.

(d) *Remanding a QIC's dismissal of a request for reconsideration*. (1) Consistent with § 405.1004(b), an ALJ or attorney adjudicator will remand a case to the appropriate QIC if the ALJ or attorney adjudicator determines that a QIC's dismissal of a request for reconsideration was in error.

(2) If an official copy of the notice of dismissal or case file cannot be obtained from the QIC, an ALJ or attorney adjudicator may also remand a request for review of a dismissal in accordance with the procedures in paragraph (a) of this section.

(e) *Relationship to local and national coverage determination appeals process*. (1) An ALJ or attorney adjudicator remands an appeal to the QIC that made the reconsideration if the appellant is entitled to relief pursuant to § 426.460(b)(1), § 426.488(b), or § 426.560(b)(1) of this chapter.

(2) Unless the appellant is entitled to relief pursuant to § 426.460(b)(1), § 426.488(b), or § 426.560(b)(1) of this chapter, the ALJ or attorney adjudicator applies the LCD or NCD in place on the date the item or service was provided.

(f) *Notice of remand*. OMHA mails or otherwise transmits a written notice of

the remand of the request for hearing or request for review to the appellant, all of the parties who were sent a copy of the request at their last known address, and CMS or a contractor that elected to be a participant in the proceedings or party to the hearing. The notice states that there is a right to request that the Chief ALJ or a designee review the remand, unless the remand was issued under paragraph (d)(1) of this section.

(g) *Review of remand*. Upon a request by a party or CMS or one of its contractors filed within 30 calendar days of receiving a notice of remand, the Chief ALJ or designee will review the remand, and if the remand is not authorized by this section, vacate the remand order. The determination on a request to review a remand order is binding and not subject to further review. The review of remand procedures provided for in this paragraph are not available for and do not apply to remands that are issued under paragraph (d)(1) of this section.

[82 FR 5121, Jan. 17, 2017, as amended at 84 FR 19871, May 7, 2019]

§ 405.1058 Effect of a remand.

A remand of a request for hearing or request for review is binding unless vacated by the Chief ALJ or a designee in accordance with § 405.1056(g).

[82 FR 5121, Jan. 17, 2017]

APPLICABILITY OF MEDICARE COVERAGE POLICIES

§ 405.1060 Applicability of national coverage determinations (NCDs).

(a) *General rule*. (1) An NCD is a determination by the Secretary of whether a particular item or service is covered nationally under Medicare.

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

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

(4) An NCD is binding on fiscal intermediaries, carriers, QIOs, QICs, ALJs and attorney adjudicators, and the Council.

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

(2) An ALJ or attorney adjudicator 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 was applied correctly to the claim.

(c) *Review by the Council.* (1) The Council may not disregard, set aside, or otherwise review an NCD for purposes of a section 1869 claim appeal, except that the DAB may review NCDs as provided under part 426 of this title.

(2) The Council 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 was applied correctly to the claim.

[70 FR 11472, Mar. 8, 2005, as amended at 70 FR 37704, June 30, 2005; 82 FR 5121, Jan. 17, 2017]

§ 405.1062 Applicability of local coverage determinations and other policies not binding on the ALJ or attorney adjudicator and Council.

(a) ALJs and attorney adjudicators and the Council are not bound by LCDs, LMRPs, or CMS program guidance, such as program memoranda and manual instructions, but will give substantial deference to these policies if they are applicable to a particular case.

(b) If an ALJ or attorney adjudicator or Council declines to follow a policy in a particular case, the ALJ or attorney adjudicator or Council decision must explain the reasons why the policy was not followed. An ALJ or attorney adjudicator or Council decision to disregard such policy applies only to the specific claim being considered and does not have precedential effect.

(c) An ALJ or attorney adjudicator or the Council may not set aside or review the validity of an LMRP or LCD for purposes of a claim appeal. An ALJ or the DAB may review or set aside an LCD (or any part of an LMRP that constitutes an LCD) in accordance with part 426 of this title.

[70 FR 11472, Mar. 8, 2005, as amended at 82 FR 5121, Jan. 17, 2017]

§ 405.1063 Applicability of laws, regulations, CMS Rulings, and precedential decisions.

(a) All laws and regulations pertaining to the Medicare and Medicaid programs, including, but not limited to Titles XI, XVIII, and XIX of the Social Security Act and applicable implementing regulations, are binding on ALJs and attorney adjudicators, and the Council.

(b) CMS Rulings are published under the authority of the Administrator, CMS. Consistent with § 401.108 of this chapter, rulings are binding on all CMS components, on all HHS components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration to the extent that components of the Social Security Administration adjudicate matters under the jurisdiction of CMS.

(c) Precedential decisions designated by the Chair of the Departmental Appeals Board in accordance with § 401.109 of this chapter, are binding on all CMS components, all HHS components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration to the extent that components of the Social Security Administration adjudicate matters under the jurisdiction of CMS.

[82 FR 5121, Jan. 17, 2017]

MEDICARE APPEALS COUNCIL REVIEW

§ 405.1100 Medicare Appeals Council review: General.

(a) The appellant or any other party to an ALJ's or attorney adjudicator's decision or dismissal may request that the Council review the ALJ's or attorney adjudicator's decision or dismissal.

(b) Under circumstances set forth in §§ 405.1016 and 405.1108, the appellant may request that a case be escalated to the Council for a decision even if the ALJ or attorney adjudicator has not issued a decision, dismissal, or remand in his or her case.

(c) When the Council reviews an ALJ's or attorney adjudicator's decision, it undertakes a *de novo* review. The Council issues a final decision or dismissal order or remands a case to the ALJ or attorney adjudicator within 90 calendar days of receipt of the appellant's request for review, unless the 90