

Centers for Medicare & Medicaid Services, HHS

§ 405.1063

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

§ 405.1100

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 calendar day period is extended as provided in this subpart.

(d) When deciding an appeal that was escalated from the OMHA level to the Council, the Council will issue a final decision or dismissal order or remand the case to the OMHA Chief ALJ within 180 calendar days of receipt of the appellant's request for escalation, unless the 180 calendar day period is extended as provided in this subpart.

[82 FR 5122, Jan. 17, 2017]

§ 405.1102 Request for Council review when ALJ or attorney adjudicator issues decision or dismissal.

(a)(1) A party to a decision or dismissal issued by an ALJ or attorney adjudicator may request a Council review if the party files a written request

42 CFR Ch. IV (10–1–24 Edition)

for a Council review within 60 calendar days after receipt of the ALJ's or attorney adjudicator's decision or dismissal.

(2) For purposes of this section, the date of receipt of the ALJ's or attorney adjudicator's decision or dismissal is presumed to be 5 calendar days after the date of the notice of the decision or dismissal, unless there is evidence to the contrary.

(3) The request is considered as filed on the date it is received by the entity specified in the notice of the ALJ's or attorney adjudicator's action.

(b) A party requesting a review may ask that the time for filing a request for Council review be extended if—

(1) The request for an extension of time is in writing;

(2) It is filed with the Council; and

(3) It explains why the request for review was not filed within the stated time period. If the Council finds that there is good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, the Council uses the standards outlined at § 405.942(b)(2) and (3).

(c) A party does not have the right to seek Council review of an ALJ's or attorney adjudicator's remand to a QIC, affirmation of a QIC's dismissal of a request for reconsideration, or dismissal of a request for review of a QIC dismissal.

(d) For purposes of requesting Council review (§§ 405.1100 through 405.1140), unless specifically excepted, the term "party", includes CMS where CMS has entered into a case as a party according to § 405.1012. The term, "appellant," does not include CMS, where CMS has entered into a case as a party according to § 405.1012.

[82 FR 5122, Jan. 17, 2017]

§ 405.1106 Where a request for review or escalation may be filed.

(a) When a request for a Council review is filed after an ALJ or attorney adjudicator has issued a decision or dismissal, the request for review must be filed with the entity specified in the notice of the ALJ's or attorney adjudicator's action. The appellant must also send a copy of the request for review to the other parties to the ALJ or