

§ 405.745

(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

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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 controversy 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 HCFA, 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) HCFA'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) HCFA'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, HCFA'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).

SOURCE: 32 FR 18028, Dec. 16, 1967, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§ 405.801 Part B appeals—general description.

(a) The Medicare carrier makes an initial determination when a request for payment for Part B benefits is submitted. If an individual beneficiary is dissatisfied with the initial determination, he or she may request, and the carrier will perform, a review of the claim. Following the carrier's review determination, the beneficiary may obtain a carrier hearing if the amount remaining in controversy is at least \$100. The beneficiary is also entitled to a carrier hearing without the benefit of a review determination when the initial request for payment is not being acted upon with reasonable promptness (as defined in § 405.802). Following the carrier hearing, the beneficiary may obtain a hearing before an ALJ if the amount remaining in controversy is at least \$500. If the beneficiary is dissatisfied with the decision of the ALJ, he or she may request the Departmental Appeals Board (DAB) to review the case. Following the action of the DAB, the beneficiary may file suit in Federal district court if the amount remaining in controversy is at least \$1,000.

(b) The rights of a beneficiary under paragraph (a) of this section to appeal the carrier's initial determination are granted also to—

(1) A physician or supplier that furnishes services to a beneficiary and that accepts an assignment from the beneficiary, or

(2) A physician who meets the conditions of section 1842(l)(1)(A) of the Act pertaining to refund requirements for nonparticipating physicians who have not taken assignment on the claim(s) at issue.