

(5) If the services furnished to a beneficiary by a physician or a supplier pursuant to an assignment under § 424.55 of this chapter are not covered because they are determined to be not reasonable and necessary under § 411.15(k) of this chapter, whether the beneficiary, physician or supplier, or a physician who meets the requirements of § 411.408, knew or could reasonably have been expected to know at the time the services were furnished that the services were not covered.

(c) The following are not initial determinations for purposes of this subpart:

(1) Any issue or factor for which SSA or HCFA has sole responsibility, for example, whether an independent laboratory meets the conditions for coverage of services; whether a Medicare overpayment claim should be compromised, or collection action terminated or suspended.

(2) Any issue or factor which relates to hospital insurance benefits under Medicare Part A.

[62 FR 25853, May 12, 1997]

§ 405.804 Notice of initial determination.

After a carrier has made an initial determination on a request for payment written notice of this determination shall be mailed to each party to the determination at his last known address. The notice of the determination shall inform each party to the determination of his right to have such determination reviewed.

§ 405.805 Parties to the initial determination.

The parties to the initial determination (see § 405.803) may be any party described in § 405.802.

[64 FR 52670, Sept. 30, 1999]

§ 405.806 Effect of Initial Determination.

The initial determination is binding upon all parties to the claim for benefits unless the determination is—

(a) Reviewed in accordance with §§ 405.810 through 405.812; or

(b) Revised as a result of a reopening in accordance with § 405.841.

[62 FR 25853, May 12, 1997]

§ 405.807 Request for review of initial determination.

(a) *General.* A party to an initial determination by a carrier, that is dissatisfied with the initial determination and wants to appeal the matter, may request that the carrier review the determination. The request for review by the party to an initial determination must clearly indicate that he or she is dissatisfied with the initial determination and wants to appeal the matter. The request for review does not constitute a waiver of the party's right to a hearing (under § 405.815) after the review.

(b) *Place and method of filing a request.* A request by a party for a carrier to review the initial determination may be made in one of the following ways:

(1) In writing and filed at an office of the carrier, SSA, or HCFA.

(2) By telephone to the telephone number designated by the carrier as the appropriate number for the receipt of requests for review.

(c) *Time of filing request.* (1) The carrier must provide a period of 6 months after the date of the notice of the initial determination within which the party to the initial determination may request a review.

(2) The carrier may, upon request by the party, extend the period for requesting the review of the initial determination.

[64 FR 52670, Sept. 30, 1999]

§ 405.808 Parties to the review.

The parties to the review (as provided for in § 405.807(a)) shall be the persons who were parties to the carrier's initial determination as described in § 405.805, and any other party whose rights with respect to the particular claim being reviewed may be affected by such review.

[39 FR 12097, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977]

§ 405.809 Opportunity to submit evidence.

The parties to the review (as provided for in § 405.807(a)) shall have a

§ 405.810

reasonable opportunity to submit written evidence and contentions as to fact or law relative to the claim at issue.

[39 FR 12097, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977]

§ 405.810 Review determination.

Subject to the provisions of §§ 405.807 through 405.809, the carrier shall review the claim in dispute and, upon the basis of the evidence of record, shall make a separate determination affirming or revising in whole or in part the findings and determination in question.

[39 FR 12097, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977]

§ 405.811 Notice of review determination.

Written notice of the review determination is mailed to a party at his or her last known address. The review determination states the basis of the determination and advises the party of his or her right to a carrier hearing when the amount in controversy is \$100 or more as determined in accordance with § 405.817. The notice states the place and manner of requesting a carrier hearing as well as the time limit under which a hearing must be requested (see § 405.821).

[59 FR 12182, Mar. 16, 1994]

§ 405.812 Effect of review determination.

The review determination is binding upon all parties to the review unless a carrier hearing decision is issued pursuant to a request for hearing made in accordance with § 405.821 or is revised as a result of reopening in accordance with § 405.841.

[59 FR 12182, Mar. 16, 1994, as amended at 62 FR 25855, May 12, 1997]

§ 405.815 Amount in controversy for carrier hearing, ALJ hearing and judicial review.

Any party designated in § 405.822 is entitled to a carrier hearing after a review determination has been made by the carrier if the amount remaining in controversy is \$100 or more and the party meets the requirements of § 405.821 of this subpart. To be entitled to a hearing before an ALJ following the carrier hearing, the amount re-

42 CFR Ch. IV (10-1-00 Edition)

maining in controversy must be \$500 or more, and for judicial review following the ALJ hearing and Departmental Appeals Board Review, the amount remaining in controversy must be \$1000 or more.

[59 FR 12182, Mar. 16, 1994, as amended at 61 FR 32348, June 24, 1996]

§ 405.817 Principles for determining amount in controversy.

(a) *Individual appellants.* For the purpose of determining whether an individual appellant meets the minimum amount in controversy needed for a carrier hearing (\$100) or ALJ hearing (\$500), 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 carrier and less any deductible and coinsurance amounts applicable in the particular case.

(2) A single beneficiary may aggregate claims from two or more physicians/suppliers to meet the \$100 or \$500 thresholds. A single physician/supplier may aggregate claims from two or more beneficiaries to meet the \$100 or \$500 threshold levels of appeal.

(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 to meet the amount in controversy for a carrier hearing only if the claims have previously been reviewed and a request for hearing has been made within six months after the date of the review determination(s).

(4) In either of the circumstances specified in paragraph (a)(2) of this section, two or more claims may be aggregated by an individual appellant to meet the amount in controversy for an ALJ hearing only if the claims have previously been decided by a carrier hearing officer and a request for an ALJ hearing has been made within 60 days after receipt of the carrier hearing officer decision(s).

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

(b) *Two or more appellants.* As specified in this paragraph, under section