DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DISMISSAL OF REQUESTS FOR ALJ HEARING AND REQUESTS FOR ESCALATION

In the case of	**Claim for**
General Medicine, P.C. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
Palmetto GBA (Contractor)	**** (ALJ Appeal Number)

INTRODUCTION

The appellant has asked the Medicare Appeals Council (Council or MAC) to review multiple cases the appellant seeks to escalate from the Office of Medicare Hearings and Appeals in Cleveland, Ohio (OMHA) without final action by an Administrative Law Judge (ALJ). *See* 42 C.F.R. §§ 405.1104, 405.1106. As set forth below, the Council finds that the appellant has failed to demonstrate that the ALJ or the Council have jurisdiction over these cases. We accordingly dismiss the appellant's requests for ALJ hearing, requests for escalation to the ALJ, and requests for escalation to the Council on multiple grounds.

BACKGROUND

This case involves individual "evaluation and management" (E&M) services provided by one physician to residents of skilled nursing facilities (SNFs) over a one-year period. The physician is a member of the appellant physician practice group.

Palmetto conducted pre-payment audits of E&M services the physician billed under HCPCS codes 99311-99313, 99302, and 99303, for a one-year period from February 2005 through January 2006. Each quarter Palmetto summarized the audit results in reports to the appellant dated May 6, 2005; August 9, 2005;

September 14, 2005; December 21, 2005; and March 31, 2006.[1] The audit reports advised the appellant that it would later receive an initial determination in a remittance advice, and that it could then request a redetermination. The audit reports further advised the appellant not to resubmit reduced or denied claims as new claims, or it might be overpaid. The appellant apparently did resubmit some claims and was overpaid.

The appellant subsequently submitted multiple appeals to an ALJ. For each case, the appellant submitted an individual appeal request with various captions. The requests were typed in standard formats with fill-in-the–blank hand written entries for certain information. Most of the individual requests read as follows:

REQUEST FOR STATUS AND REQUEST FOR MEDICARE PART B HEARING BY AN ADMINISTRATIVE LAW JUDGE

> We are requesting the status of our reconsideration request which was mailed to you on [date]. We received the Reconsideration acknowledgement which is dated N/A. It has now been more that 60 days and we have not received a decision on this claim.
>
> Please advise us immediately as to the status of our claim. **If you have denied our claim, then we are formally requesting a Hearing by an Administrative Law Judge to appeal this dismissal and our denial of payment.**

A variant of this form used in some cases reads:

REQUEST FOR STATUS AND REQUEST FOR MEDICARE PART B HEARING BY AN ADMINISTRATIVE LAW JUDGE

> On N/A, we requested a ruling. We have not received a response to this request. Given your lack of response, we hereby request a Hearing by an Administrative Law Judge to appeal this dismissal and denial of our claim for payment.

[1] These letters covered claims processed from February - April 2005, May - July 2005, August - October 2005, and November - January 2006, respectively.

A minority of the requests read:

REQUEST FOR ESCALATION APPEAL TO ALJ

> We are requesting this appeal to an administrative law judge due to the Q.I.C. not granting us a decision within 60 days. Your correspondence is dated [date of summary audit report] informing us of our options.

A variant of this form used in a few requests reads:

REQUEST FOR ESCALATION APPEAL TO ALJ

> We are requesting this appeal to an administrative law judge due to the *Hearing Officer* not granting us a decision within 60 days. Your correspondence is dated N/A informing us of our options.

(Emphasis supplied.)

Other requests read:

REQUEST FOR MEDICARE PART B HEARING BY AN ADMINISTRATIVE LAW JUDGE

> We are requesting a hearing by an administrative law judge to appeal the Q.I.C. unfavorable decision dated [N/A] [or a date] denying our claim for payment with regard to the above-referenced beneficiary and date of service.

The appellant grouped these individual appeal requests and mailed them to the OMHA Field Office in Cleveland, Ohio, under cover of several letters captioned "Medicare Part B Administrative Law Judge Hearing Request." Each letter states "[w]e would like to request an Administrative Law Judge Appeal and have them **aggregated into the same hearing** in regards to the following [xx] claims. In total, the appellant filed the following letters requesting hearings:

- February 23, 2007, for 23 claims, lead beneficiary ****;[2]

[2] This letter refers to an additional 84 claims for which a request for hearing was previously filed, but does not identify when the previous requests for hearing were filed.

- February 23, 2007, for 22 claims, lead beneficiary ****;
- February 23, 2007, for 9 claims, lead beneficiary ****;
- February 23, 2007, for 44 claims, lead beneficiary ****;
- March 19, 2007, for 177 claims, lead beneficiary ****;
- March 20, 2007, for 192 claims, lead beneficiary ****;
- March 22, 2007, for 220 claims, lead beneficiary ****; and
- April 16, 2007, for 3 claims, lead beneficiary ****;

The appellant sent a "Request for Escalation to the Medicare Appeals Council" dated May 25, 2007, to the OMHA Field Office, which OMHA date-stamped received on May 29, 2007. Attachment 1. On June 4, 2007, the Medicare Appeals Council received a similar "Request for Escalation to the Medicare Appeals Council" dated May 25, 2007, but addressed to the Council. Attachment 2. The appellant stated that it wanted to escalate "all pending Administrative Law Judge requests that are waiting to be heard to the Medicare Appeals Council" because "it has well exceeded the statutory time limit of 90 days established in section 42 C.F.R. § 405.1016 of the Medicare Handbook." The request covered 174 beneficiaries with 645 dates of service.

By letter dated June 6, 2007, Acting Managing ALJ Pastrana sent the appellant an "Acknowledgement of Request for Escalation" (Acknowledgement). Attachment 3. ALJ Pastrana's letter advised the appellant that the status of each of the listed beneficiaries and dates of service varied within the ALJ appeals process. The letter further informed the appellant that it had previously agreed on June 2, 2006, to waive the ninety-day adjudication deadline for appeals under six ALJ Appeal Numbers, which include 165 requests for hearing, some of which involved multiple DOS for a beneficiary. On July 13, 2007, Managing ALJ Davis issued a "Notice of Escalation" (Notice) and "Order of Escalation" (Order) for the appeals for which the appellant had not waived the adjudication deadline. Attachments 4 and 5, respectively.

On July 17, 2007, the Council received eight boxes of claims files from OMHA in response to the escalation request.[3] The shipment contained a second request for escalation, dated June 11, 2007, addressed to an individual in the OMHA Field Office. This second request covered twenty-one beneficiaries with one date of service each. Attachment 6.

In the interim, Managing ALJ Davis sent a letter to the appellant dated July 5, 2007, setting forth his understanding that the appellant was initiating a standing request for escalation. Attachment 7. Managing ALJ Davis stated that the OMHA Field Office would begin escalation of pending requests for hearing as the applicable adjudication period expired on a "rolling" basis. The letter also advised the appellant that a document dated June 29, 2007, captioned "**REQUEST FOR STATUS AND REQUEST FOR MEDICARE PART B HEARING BY AN ADMINISTRATIVBE LAW JUDGE**" (Request for Status) should be directed to the QIC if it is a request for escalation, as the document cannot be construed as a request for hearing.

On August 3, 2007, Managing ALJ Davis issued an Acknowledgement, Order, and Notice for appeals on seven beneficiaries, some with multiple dates of service. Attachment 8. The Acknowledgement stated that the appeals were being escalated on a rolling basis per the standing request for escalation. For six beneficiaries, the individual requests for hearing were made on a Request for Status, which listed January 5, 2006, as the date of the request for reconsideration. However, each request also attached the quarterly audit report of the same date. The appellant's submissions did not include a copy of any previous appeal request at any level. No individual request for hearing is in the file for the seventh beneficiary.

LEGAL STANDARDS

Introduction

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)(Pub. L. 106-554) amended section 1869 of the Social Security Act (Act) to change the Medicare claim appeals process. Title IX of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)(Pub. L. 108-73) further changed the appeals process. CMS

[3] To ease identification, we may refer herein to cases located in certain boxes.

issued an Interim Final Rule implementing the statutory changes on March 8, 2005, 70 Fed. Reg. 11420.[4] These regulations are codified at 42 C.F.R. part 405, subpart I.

The Interim Final Rule specified an effective date of May 1, 2005. 70 Fed. Reg. 11420. However, CMS noted that not all sections of the new regulation could be implemented simultaneously for both Medicare Part A and Part B. Accordingly, the regulation included an implementation schedule, setting forth different dates for implementation of specified portions of the regulations. *Id.* at 11425. The implementation schedule states that 42 C.F.R. § 405.1104, governing a request for Council review when an ALJ does not issue a decision timely (a request for escalation), is "[e]ffective for all appeal requests stemming from a QIC [Qualified Independent Contractor] reconsideration." *Id.* at 11425. Commentary to the rule further states:

> [T]he new reconsideration and escalation procedures will take effect for all *carrier redeterminations issued on or after January 1, 2006*. Thus, in 2006, all new appeals will be carried out under the regulations set forth in this interim final rule, including provisions on -
>
> - Reconsiderations by QICs;
> - The new statutory time frames for reconsiderations, ALJ hearings, and MAC reviews;
> - The possibility of escalation of cases where the time frames are not met;
> - The new notice and evidence rules; and
> - Medicare-specific ALJ procedures.

Id. (Emphasis supplied.)

Generally, a Medicare carrier makes the first coverage decision on Part B benefits, referred to as an initial determination. A party dissatisfied with an initial determination may request that the carrier conduct a redetermination. A party dissatisfied with a redetermination may then appeal to a QIC for a reconsideration. A party dissatisfied with a reconsideration may then request an ALJ hearing "if the amount remaining in

[4] CMS issued technical corrections to the Interim Final Rule on June 30, 2005. Correcting Amendment to an Interim Final Rule, 70 Fed. Reg. 37700 (June 30, 2005).

controversy and other requirements for an ALJ hearing are met." ALJ decisions may be appealed to the Medicare Appeals Council, and from there to federal court. 42 C.F.R. § 405.904(a)(2); *see also* 42 C.F.R. §§ 405.920, 405.940, 405.960, 405.1000, 405.1100, 405.1136.

Escalation from a QIC to an ALJ

A case may be "escalated" from the QIC to the ALJ level when a decision is not issued within case adjudication timelines. The QIC generally has 60 days to complete a reconsideration before a party, unless the QIC grants an extension of time. At the end of the adjudication period, the QIC must either issue a reconsideration or notify all parties that it cannot complete the reconsideration by the deadline and offer the appellant the opportunity to escalate an appeal to an ALJ. The QIC continues to process the reconsideration request unless it receives a written request from the appellant to escalate the case to an ALJ. If the appellant submits this request, the QIC must complete the reconsideration within five days of receipt of the notice or five days from the end of the applicable adjudication period, or acknowledge the request and forward the case file to the ALJ Field Office. 42 C.F.R. § 405.970. No separate request for hearing need be filed. The ALJ's 180-day adjudication period to issue a decision begins when the ALJ receives with the file with the request for escalation from the QIC. 42 C.F.R. § 405.1016(c).

Request for ALJ Hearing

If a QIC does not escalate a case, an appellant must file a request for hearing after a QIC decision. A valid request for hearing must satisfy all of the following requirements:

> (a) Content of the request. The request for an ALJ hearing must be made in writing. The request must include all of the following—
> (1) The name, *address*, and Medicare health insurance claim number of the beneficiary whose claim is being appealed.
> (2) The name and address of the appellant, when the appellant is not the beneficiary.
> (3) The name and address of the designated representatives if any.
> (4) *The document control number assigned to the appeal by the QIC, if any*.

(5) The dates of service.
(6) The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed.
(7) A statement of any additional evidence to be submitted and the date it will be submitted.
(b) When and where to file. The request for an ALJ hearing after a QIC reconsideration must be filed—
(1) Within 60 days from the date the party receives notice of the QIC's reconsideration;
(2) With the entity specified in the QIC's reconsideration. *The appellant must also send a copy of the request for hearing to the other parties. Failure to do so will toll the ALJ's 90-day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing.* If the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the deadline specified in §405.1016 for deciding the appeal begins on the date the entity specified in the QIC's reconsideration receives the request for hearing. If the request for hearing is filed with an entity, other than the entity specified in the QIC's reconsideration, the ALJ hearing office must notify the appellant of the date of receipt of the request and the commencement of the 90-day adjudication time frame.

42 C.F.R. § 405.1014 (emphasis supplied).

Amount in Controversy Required for an ALJ Hearing

The appellant must meet the amount in controversy requirements to establish jurisdiction for an ALJ hearing, including any appeal escalated from the QIC. 42 C.F.R. §§ 405.1002(b) and 405.1006. For 2007, $110 is the required amount in controversy required to establish jurisdiction for an ALJ hearing.[5] The amount in controversy is computed as the actual amount charged for a service, reduced by any applicable coinsurance and deductible amounts.

An appellant can combine smaller claims to meet the amount in controversy requirements through aggregation. 42 C.F.R. § 405.1006(e). For all cases subject to the new BIPA and MMA appeals process in 42 C.F.R. subpart I, the appellant must specify in an aggregation request all claims that the appellant seeks to aggregate and state "why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services." 42 C.F.R. § 405.1006(f). The ALJ must then make a determination "that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services." 42 C.F.R. § 405.1006(e)(1)(iii) and (e)(2)(iii).

Escalation from an ALJ to the Medicare Appeals Council

Assuming that an appellant has satisfied the amount in controversy and other jurisdictional requirements, an ALJ then has ninety days from receipt of a perfected request for hearing to issue a decision, dismissal, or remand order when the QIC issued a reconsideration. The ALJ has 180 days from receipt of the request for escalation to act on a case escalated without a QIC reconsideration. 42 C.F.R. § 405.1016. If the applicable adjudication period expires without action, section 1869(d)(3) of the Act provides:

> In the case of a failure by an administrative law judge to render a decision by the end of the [applicable adjudicatory period], the party requesting

[5] Currently, "[f]or ALJ hearing requests, the required amount remaining in controversy must be $100" subject to percentage increases related to the consumer price index. 42 C.F.R. § 405.1006(b)(1).

> the hearing *may request a review by the [Medicare Appeals Council],* notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

(Emphasis supplied).

The implementing regulations impose the following requirements for escalating a case for MAC review:

> An appellant who has filed a timely request for hearing before an ALJ and whose appeal continues to be pending before the ALJ at the end of the applicable ALJ adjudication period in 42 C.F.R. § 405.1016 *may request MAC review if* -
>
> (1) The appellant files a written request *with the ALJ* to escalate the appeal to the MAC *after the adjudication period has expired*; *and*
>
> (2) The ALJ does not issue a final action or remand the case to the QIC within the later of 5 days of receiving the request for escalation or 5 days from the end of the applicable adjudication period set forth in § 405.1016.

42 C.F.R. § 405.1104(a) (emphasis supplied).

Once the appellant files a valid request that satisfies these conditions, the ALJ must then send notice to the appellant as follows:

> (b) Escalation. (1) If the ALJ is not able to issue a final action or remand within the time period set forth in paragraph (a)(2) of this section, *he or she sends notice to the appellant*.
> (2) The notice acknowledges receipt of the request for escalation, and confirms that the ALJ is not able to issue a final action or remand order within the statutory time frame.
> (3) If the ALJ does not act on a request for escalation within the time period set forth in paragraph (a)(2) of this section or does not send the required notice to the appellant, *the QIC decision becomes a final administrative decision for purposes of MAC review*.

42 C.F.R. § 405.1104(b) (emphasis supplied).

Thus, the ALJ must first send a notice, which acknowledges receipt of the request for escalation, and confirms that the ALJ is not able to issue a final action or remand order within the statutory period. 42 C.F.R. § 405.1104(b)(2). The QIC decision then becomes the final administration decision for MAC review if the ALJ does not issue an action within the five day time period, or send the required notice. 42 C.F.R. § 405.1104(b)(3).

If the ALJ's adjudication period expires, the regulations further provide:

> (c) No escalation. If the ALJ's adjudication period set forth in §405.1016 expires, the case remains with the ALJ until a final action is issued *or the appellant requests escalation to the MAC*.

42 C.F.R. § 405.1104(c) (emphasis supplied).

The regulations further specify where an appellant must file a request for MAC review of an escalated case:

> If an appellant files a request to escalate an appeal to the MAC level because the ALJ has not completed his or her action on the request for hearing within the adjudication deadline under §405.1016, the request for escalation must be filed with both the ALJ and the MAC. *The appellant must also send a copy of the request for escalation to the other parties. Failure to copy the other parties tolls the MAC's adjudication deadline set forth in § 405.1100 until all parties to the hearing receive notice of the request for MAC review.* In a case that has been escalated from the ALJ, the MAC's 180-day period to issue a final action or remand the case to the ALJ begins on the date the request for escalation is received by the MAC.

42 C.F.R. § 405.1106(b) (emphasis supplied).

The specific requirements for the content of a valid request for review/escalation are:

> The request for review must be in writing and may be made on a standard form. A written request that is not made on a standard form is accepted if it contains

> the beneficiary's name; Medicare health insurance claim number; the specific service(s) or item(s) for which the review is requested; the specific date(s) of service; ... if the party is requesting escalation from the ALJ to the MAC, the hearing office in which the appellant's request for hearing is pending; and the name and signature of the party or the representative of the party; and any other information CMS may decide.

42 C.F.R. § 405.1112

The Council may take the following actions after receiving an escalated case that satisfies the jurisdictional requirements:

> (1) Issue a decision based on the record constructed at the QIC and any additional evidence, including oral testimony, entered in the record by the ALJ before the case was escalated.
> (2) Conduct any additional proceedings, including a hearing, that the MAC determines are necessary to issue a decision.
> (3) Remand the case to an ALJ for further proceedings, including a hearing.
> (4) Dismiss the request for MAC review because the appellant does not have the right to escalate the appeal.
> (5) Dismiss the request for a hearing for any reason that the ALJ could have dismissed the request.

42 C.F.R. § 405.1108(d).

DISCUSSION

Escalation is a narrow departure from well-established legal principles that require exhaustion of remedies. Generally, there is no right to appeal to a higher level without first receiving a decision. In this case, the appellant has created considerable confusion by styling almost all of its appeals as a request for escalation, without establishing that it has any right to escalate an appeal.

In large part, this is due to the appellant’s repeated failure to follow the requirements of the regulations throughout the appeals process. The Council has carefully reviewed the appellant’s multiple submissions. We find that the appellant

has failed to establish that an ALJ or the Council has jurisdiction over his requests for escalation to an ALJ, requests for hearing, or requests for escalation to the Council. Moreover, through his failure to follow the requirements of the regulations, appellant has not demonstrated that any applicable adjudication period has even begun. We discuss in detail below why the appeals fail on multiple grounds.

Escalation from the QIC to an ALJ

The Request for Escalation must be filed with the QIC

The appellant filed multiple requests for status or escalation from the QIC with the ALJ. The regulations require that the appellant file a request for escalation with the QIC, not with the ALJ. 42 C.F.R. § 405.970. The appellant has not properly requested escalation of any case from the QIC to the ALJ, because it did not file a request for escalation with the QIC. If the appellant had filed a proper request with the QIC, the QIC would have forwarded the file and the request to the ALJ, as provided in 42 C.F.R. § 405.970(e)(2)(ii).

There is No Right to Request Escalation or an ALJ Hearing in all Cases

In some cases, the appellant has requested escalation in cases that are not subject to the provisions of 42 C.F.R. part 405, subpart I. Escalation is only permissible if a carrier issues a redetermination on or after January 1, 2006, and the appellant files a valid request for QIC reconsideration. Although the appellant has not submitted the redetermination in most cases, it is probable that any appeal from the initial determinations associated with the quarterly audit report summaries dated May 6, 2005, and August 9, 2005, would have resulted in the carrier issuing a redetermination before the end of 2005. The appellant's next appeal step would have been to request a carrier hearing, rather than request a QIC reconsideration. In fact, some cases involve appeal requests that were filed under the previous regulations in 42 C.F.R. part 405, subpart H, that are within the jurisdiction of a carrier hearing officer. There is no right to escalate an appeal under those regulations. Box 7.

In other cases, the appellant has sought to escalate to the ALJ or the Council matters that are not subject to escalation under 42 C.F.R. part 405, subpart I. A QIC may review a carrier's

dismissal of a redetermination request, but there is no right to further appeal beyond the QIC. 42 C.F.R. § 405.974. The appellant nevertheless filed a Request for Status in some of these cases and requested escalation to the Council. *See, e.g.,* **** (Box 6); Undated QIC action affirming the carrier's June 27, 2006, dismissal of a redetermination request for untimely filing; February 23, 2007 Request for Status and request for hearing; May 25, 2007, request for escalation to the Medicare Appeals Council; and July 13, 2007 ALJ Acknowledgement, Notice, and Order.

An ALJ may, however, review a QIC's action dismissing a request for reconsideration under 42 C.F.R. § 405.1004. The ALJ's decision regarding the QIC's dismissal is final and not subject to further review. There is no right to escalate these cases from an ALJ to the Medicare Appeals Council, because only a QIC decision can be a final administrative decision for purposes of review by the Council. 42 C.F.R. § 405.1104(b)(3). A QIC dismissal does not qualify as a QIC decision under 42 C.F.R. §§ 405.972 and 405.974(a). Notwithstanding this, the appellant requested escalation to the Council in some of these cases. *See, e.g.,* **** (Box 6); January 2, 2007, QIC dismissal for untimely filing; February 23, 2007 Request for Status and request for hearing; May 25, 2007, request for escalation to the Medicare Appeals Council; and
July 13, 2007 ALJ Acknowledgement, Notice, and Order.

No Request for QIC Reconsideration or Redetermination Notice

In almost all cases, the appellant has not demonstrated that it filed a timely request for reconsideration after a redetermination dated January 1, 2006, or later. Both of these events are prerequisites to the right to escalate an appeal to the ALJ under 42 C.F.R. part 405, subpart I.

The appellant attached various documents to its appeals requests. These documents usually contain a copy of one of the quarterly audit reports. They do not contain copies of subsequent requests for redetermination, redetermination notices, or requests for reconsideration. The appellant has not provided with its filings evidence of a carrier redetermination and subsequent timely request for QIC reconsideration. Both are required to establish that an ALJ ever had jurisdiction over a request for escalation. The individual appeal requests contain

either an “N/A” for the date of the previous appeal request, an “N/A” for date of an reconsideration or redetermination, or the date of the quarterly audit report. Boxes 1 through 5.

Failure to Meet the Amount in Controversy

A party has a right to an ALJ hearing (including escalation), in part, if the amount remaining in controversy is at least $110 in 2007. The amount in controversy is computed as the actual amount billed, reduced by any applicable coinsurance or deductible. The coinsurance is twenty percent. The amount in controversy is a statutory jurisdictional requirement.

These cases involve five different E&M codes. The appellant billed the following amounts for these codes:

99311 - $49.00

99312 - $75.00

99313 - $99.00

99302 - $113.00

99303 – $140.00

After reducing the amount billed by a twenty percent coinsurance, the amount in controversy is over the $110 jurisdictional amount only for code 99303.

An appellant may request to aggregate two or more smaller claims to meet amount in controversy requirements, and the ALJ must determine that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services. 42 C.F.R. § 405.1006(e).[6] For any request subject to the new procedures in 42 C.F.R. § part 405, subpart I, an appellant’s request for aggregation contained in a request for ALJ hearing must:

> (1) Specify all of the claims the appellant(s) seek to aggregate; and

[6] “Delivery of similar or related services” is defined as meaning “like or coordinated services or items provided to one or more beneficiaries.” 42 C.F.R. § 405.1006(a)(2).

> (2) State why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services.

42 C.F.R. § 405.1006(f).

The appellant filed multiple requests for ALJ hearings dated February 23, 2007 (dated stamped received by OMHA on February 26, 2007), and subsequent requests for ALJ hearings dated March 19, 2007 (received April 7, 2007), March 20, 2007 (received April 7, 2007), March 22, 2007 (received April 2, 2007), and April 16, 2007 (received April 17, 2007). Each request states, in relevant part, "We would like to request an Administrative Law Judge Appeal and have them aggregated into the same hearing in regards to the following [listed] claims."

None of these requests for aggregation satisfy the regulatory requirement that the appellant state why the claims involve the delivery of similar or related services. The appellant's failure to specify how the claims listed on the respective requests for ALJ hearings/escalation involved the delivery of similar or related services causes its requests for aggregation to fail. Consequently, the appellant did not satisfy the amount in controversy requirements for any of the ALJ hearings requested except those few that involved code 99303.

In addition, the regulations impose an additional requirement for requests for aggregation in claims that are escalated from the QIC level to the ALJ level. An appellant may aggregate two or more claims that are escalated from the QIC level to the ALJ level only if *"the claims were pending before the QIC in conjunction with the same request for reconsideration*." 42 C.F.R. § 405.1006(e)(2)(i)(emphasis supplied). In contrast, in requesting a hearing after a QIC reconsideration an appellant may aggregate claims so long as the claims were previously considered by a QIC in one or more reconsiderations. *Compare* 42 C.F.R. § 405.1006(e)(1)(i). The appellant has not shown that the claims for which aggregation is sought were pending before the QIC in conjunction with the same request for reconsideration.

Request for ALJ Hearing

The Requests for ALJ Hearing are Not Valid

Even though the appellant has not demonstrated that it had the right to escalate any case from the QIC to the ALJ, the Council has considered whether the appellant filed valid requests for an ALJ hearing. We find that the appellant failed to do so.

The requirements for a request for hearing are found in 42 C.F.R. § 405.1014, for those cases subject to the new BIPA/MMA appeals processes found in 42 C.F.R. part 405, subpart I. The request must include the beneficiary's address. *Id.* at (a)(1). This required information is not found in any of the requests for hearing. Almost all of the requests for hearing also lack a QIC control number, which is also required by regulation. The requests for hearing are therefore incomplete and invalid.

In addition, substantially all of the requests for hearing do not demonstrate that they were timely filed after any QIC reconsideration. A request for hearing must be filed within sixty days of the date the party receives notice of a QIC reconsideration. The appellant has generally failed to demonstrate that it exhausted administrative remedies by requesting and receiving a QIC reconsideration within sixty days before the request for hearing.

Similarly, for those pre-BIPA/MMA cases subject to the appeals processes found in 42 C.F.R. part 405, subpart H, an appellant must file a request for hearing with sixty days after receiving a carrier hearing decision. 42 C.F.R. §§ 405.801, 405.855 and 20 C.F.R. § 404.933. The appellant has failed to demonstrate that it exhausted administrative remedies by requesting and receiving a carrier hearing decision within sixty days before the request for hearing.

Escalation from the ALJ to the Medicare Appeals Council

Filing Requirements for Council Review

Section 1869(d)(3) of the Act provides that an appellant "may request a review" by the Council after the expiration of the applicable statutory time frame for ALJ adjudication. The implementing regulations provide that an appellant may request MAC review if the appellant first files a written request with the ALJ to escalate the appeal after the adjudication period has

expired. 42 C.F.R. § 405.1104(a). If the ALJ does not act within five days, the QIC decision becomes a final administrative decision for purposes of MAC review. *Id.* at (b). However, the case remains with the ALJ unless the appellant then requests MAC review of an escalated case. *Id*. at (c). An appellant may file a request for MAC review of an escalated case because the ALJ has not completed his or her action in the applicable timeframe. 42 C.F.R. § 405.1106(b). The appellant must send a copy of this request to both the ALJ and the MAC. *Id.*

In this case, the appellant sent to both OMHA and the Council written requests dated May 25, 2007, and June 11, 2007, to escalate appeals pending before the ALJ. ALJ Davis then issued the Notice dated July 13, 2007, which provided only that the cases subject to the appellant's previous filings "ha[d] been escalated." Attachment 4. The accompanying Order, also dated July 13, 2007, declared that the adjudication period set forth in 42 C.F.R. § 405.1104(a)(2) had expired without an adjudication and that the associated cases were therefore escalated under 42 C.F.R. § 405.1104. Attachment 5.

The appellant's requests for escalation fail to comply with the filing requirements set forth in 42 C.F.R. §§ 405.1104 and 405.1106. The appellant never filed proper requests for MAC review of escalated cases, after it received notice that the ALJ was unable to adjudicate the subject claims within the remaining adjudicatory timeline. The regulations state that an appellant may request MAC review of an escalated case after it first files a request for escalation with the ALJ, and the ALJ issues notice of the ALJ's inability to adjudicate the cases within the applicable timeframe. 42 C.F.R. § 405.1104(a)(1). Once the ALJ has provided notice to the appellant of the cases that can and cannot be completed, the appellant must then separately request MAC review of any escalated cases. This separate request for review of an escalated case must be filed with both the MAC and the ALJ. 42 C.F.R. § 405.1106(b). The request must also contain the required content for a request for review of an escalated case set forth in 42 C.F.R. § 405.1112. Only then should an ALJ forward those cases to the Council for its review.

Significantly, the Council's adjudication timeframe does not start until the date the request for review of an escalated case is received by the MAC. 42 C.F.R. § 405.1106(b). If the

regulations required only a single request for escalation filed concurrently with both the ALJ and the MAC, then the Council's adjudication timeline would run concurrently with some or all of the ALJ adjudication timeline.

Moreover, the appellant must send a copy of the request for review of an escalated case to all parties, as well as to the ALJ and Council. 42 CR § 405.1014(b)(2). Failure to do so tolls the Council's adjudication deadline until all parties receive a copy of the request for review of an escalated case. In contrast, there is no requirement under 42 C.F.R. § 405.1104 that an appellant send a copy of the first request for escalation to all parties, or to the Council.

The Council's jurisdiction and adjudicative responsibilities can only be triggered after the ALJ has completed his or hers. Any other interpretation is inconsistent with the plain language of the regulations considered as a whole. Accordingly, the appellant has not established jurisdiction for Council review merely by filing a single request for escalation simultaneously with the Council and ALJ.

An Appellant must File a Request for Escalation after Expiration of the Adjudication Period

As set forth above, the statute and regulations contemplate that an appellant will file a request for escalation from the ALJ to the MAC after expiration of the adjudication period. Unlike proceedings before the QIC, the ALJ has no affirmative obligation to notify the appellant of the expiration of the adjudication period. The Council believes that construing a prematurely filed request for escalation as a "standing request" shifts the burden to the ALJ. It also conflicts with the requirement that an appellant file a request for escalation after expiration of the adjudication period.

The ALJ has 180 days to Act in Cases Escalated from the QIC

Even if the appellant had properly escalated an appeal from the QIC to an ALJ, and from an ALJ to the Council, the appellant's request for review of an escalated case would be premature in a substantially all cases. The ALJ had 180 days to act after receiving the request and file from the QIC. One hundred-eighty days have not yet passed since the first request for escalation received by the ALJ on February 26, 2007. The appellant has not established that escalation of any case to the Council is ripe.

The ALJ's Adjudication Period Never Began on a Request for Hearing

In the alternative, the appellant's adjudication period after a request for hearing never began. The appellant must send a copy of the request for hearing to all parties, including the beneficiary. 42 CR 405.1014(b)(2). Failure to do so tolls the ALJ's adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing. There is no evidence that the appellant sent the required copy of the request for hearing to the beneficiary. Thus, even if the appellant had filed a valid request for hearing, the ALJ's adjudication period never began for purposes of escalation from the ALJ to the Medicare Appeals Council.

Waiver of ALJ Adjudication Deadline

The appellant signed written waivers of the 90-day ALJ adjudication deadline in six cases pending an ALJ hearing, involving approximately 200 individual claims. Attachment 9. The written waivers indicate the appellant's understanding that waiving the deadline will allow enough time for ALJ hearings and decisions. These waived cases include claims that the appellant asked be escalated to the Council. *Compare* Attachment 1. As the appellant has waived the ALJ adjudication period, it has no right to escalate those cases to the Council for review.

CONCLUSION

The Council may dismiss any request for ALJ hearing for any reason for which the ALJ could have dismissed the request. 42 C.F.R. § 405.1108(d)(5). An ALJ may dismiss a request for hearing if an appellant has no right to a hearing, including no right to escalation. 42 C.F.R. §§ 405.1002, 405.1052(a)(3). The Council's dismissal of a request for hearing is binding and not subject to judicial review. 42 C.F.R. § 405.1116. The Council may also dismiss the request for review because the appellant has no right to review or no right to escalate the appeal. 42 C.F.R. §§ 405.1108(d)(4), 405.1114. The Council's dismissal of a request for review is also binding and not subject to judicial review. 42 C.F.R. § 405.1116.

The Council hereby dismisses the appellant's requests for escalation to an ALJ, requests for ALJ hearing, and requests for escalation to the Council on multiple grounds as set forth above.

MEDICARE APPEALS COUNCIL

Clausen J. Krzywicki
Administrative Appeals Judge

Constance B. Tobias, Chair
Departmental Appeals Board

Date: September 6, 2007