

## **Chapter I-7    Adjudication Time Frames**

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## I-7-1 Adjudication Time Frames, Generally

Citations: [§ 1869 of the Act](#); [§§ 405.974\(b\), 405.1016, 405.1104, 423.2016](#)

**NOTE:** The CMS contractors described in the regulations as Independent Review Entities (IREs) or Independent Outside Entities (IOEs) are commonly referred to as Part C QICs or Part D QICs. This manual adopts this common usage and uses the term “Part C QIC” or “Part D QIC” as appropriate, for ease of identification only.

### A. Generally

For Medicare Part A and Part B, [§ 1869 of the Act](#) establishes time frames for adjudicating Medicare claims appeals and, after the redetermination level, a mechanism to escalate appeals that were not adjudicated within the time frame. For the ALJ level, the statute provides for a 90-day adjudication time frame for appeals of QIC reconsiderations. HHS regulations implement this time frame, as well as prescribe a 180-day time frame for adjudicating an appeal that was escalated from the QIC to the ALJ level. [§ 405.1016\(a\) and \(c\)](#).

HHS regulations also establish time frames for appeals of Part D plan sponsor coverage determinations. [74 Fed. Reg. 65340, 65343-65345 \(Dec. 9, 2009\)](#). At the ALJ level, the regulations provide for a 10-day adjudication time frame when an appeal qualifies for an expedited hearing, or a 90-day adjudication time frame for a standard (that is, not expedited) appeal. [§ 423.2016\(a\) and \(b\)\(5\)](#). However, there is no provision to escalate Part D appeals that were not adjudicated within the adjudication time frame. [74 Fed. Reg. 65340, 65344 \(Dec. 9, 2009\)](#).

### B. Part A and B Appeals

#### 1. QIC reconsiderations.

Appeals of Part A and Part B QIC reconsiderations are subject to a 90-day adjudication time frame, except when certain events, defined in [I-7-2](#) extend or toll it. The start of the 90-day adjudication time frame also can be delayed in certain circumstances, as defined in [I-7-2](#). An appellant may request an escalation to the Medicare Appeals Council if the adjudication time frame is not met. [§§ 405.1016\(a\), 405.1104\(a\)](#).

**NOTE:** A QIC’s reconsideration of a contractor’s dismissal of a redetermination request is binding and not subject to review by OMHA. [§ 405.974\(b\)](#).

#### 2. Escalations of requests for QIC reconsiderations.

Escalations of requests for Part A and Part B QIC reconsiderations are subject to a 180-day adjudication time frame, except when certain events, defined in [I-7-2](#), extend or toll

it. An appellant may request an escalation to the Medicare Appeals Council if the ALJ adjudication time frame is not met. [§§ 405.1016\(c\), 405.1104\(a\)](#).

**3. Other Part A and Part B appeals.**

The statute and regulation do not establish an adjudication timeframe for appeals under Part A and Part B that are not appeals of QIC reconsiderations or escalations of requests for a QIC reconsideration. These actions include, but are not limited to appeals of: QIC dismissals of requests for reconsideration; QIO reconsiderations; and SSA reconsiderations of eligibility or entitlement to Medicare, Part B late enrollment penalties, or Part B Income Related Monthly Adjustment Amounts (IRMAAs). [74 Fed. Reg. 65296 \(Dec. 9, 2009\)](#), [67 Fed. Reg. 69312 \(Nov. 15, 2002\)](#), [74 Fed. Reg. 65340 \(Dec. 9, 2009\)](#).

**C. Part C Appeals**

Appeals of Part C QIC or Part C QIO reconsidered determinations are not subject to a statutory adjudication time frame.

**D. Part D Appeals**

**1. Part D QIC reconsiderations.**

Appeals of Part D QIC reconsiderations are subject to a 10-day (expedited appeals) or 90-day (standard appeals) adjudication time frame, except when certain events, defined below, extend or toll it. The start of the adjudication time frame also can be delayed in certain circumstances, as defined below.

**2. Other Part D appeals.**

The statute and regulation do not establish an adjudication time frame for appeals under Part D that are not appeals of QIC reconsiderations. These actions include, but are not limited to, appeals of the Part D QIC's dismissal of a request for reconsideration and an SSA reconsideration of a Part D IRMAA (which is generally part of a Part B IRMAA appeal when the Part B beneficiary has also enrolled in a Part D prescription drug plan).

**E. Remands from Council**

Adjudication time frames only apply in types of appeals identified in subsections **A** through **D** above. The provisions of [§§ 405.1016 and 423.2016](#) do not apply to cases remanded from Council, even if those provisions applied to the case when OMHA first reviewed it.

## **I-7-2 Events that Delay the Start of or Extend Adjudication Time Frames**

Citations: [§ 1869 of the Act](#); [§§ 405.1014, 405.1016, 405.1018, 405.1020, 405.1030, 405.1036, 405.1037, 423.2014, 423.2018, 423.2020, 423.2036, 423.2042](#)

### **A. Adjudication Time Frames Established by Statute or Regulation**

Adjudication time frames established by statute or regulation may be subject to events that delay the start of or extend the adjudication time frame. These events are specified in regulation, except that a federal court may also stay (that is, suspend) proceedings in a pending administrative adjudication.

#### **1. Events that delay the start of the adjudication time frame.**

- The appellant files the request for hearing with an entity other than the entity specified in the QIC's or Part D QIC's reconsideration. [§§ 405.1014\(b\)\(2\), 423.2014\(c\)\(2\)\(i\)](#).

See [II-3-5 B](#) for the effect a misfiled request for hearing has on timely filing.

- The request for hearing is untimely. [§§ 405.1014\(c\), 405.1016\(b\), 423.2014\(d\), 423.2016\(a\)\(2\) and \(b\)\(5\)](#).

See [II-3-5 A](#) for general information on timely filing.

#### **2. Events that extend the adjudication time frame.**

- The appellant in a Part A or Part B appeal fails to send a copy of the request for hearing to the other parties. [§ 405.1014\(b\)\(2\)](#). See [II-3-6 C](#) for more information on the copy requirement.
- A party submits written evidence later than 10 calendar days (2 calendar days for Part D expedited appeals) after receiving the notice of hearing, unless the party is an unrepresented beneficiary in a Part A or Part B appeal, or an unrepresented enrollee in a standard (that is, not expedited) Part D appeal. [§§ 405.1018\(b\), \(d\); 423.2018\(b\)\(2\), \(b\)\(3\), \(c\)\(2\)](#).
- The hearing is rescheduled at the request of the appellant in a Part A or Part B appeal, or the enrollee in a Part D appeal. [§§ 405.1020\(h\), 423.2020\(h\)](#). See [II-7](#) and [IV-7](#) for more information on appellant requests to reschedule a hearing.
- The ALJ identifies material missing evidence at the hearing in a Part A or Part B appeal; the evidence is in the possession of the appellant; the appellant is a provider, supplier, or beneficiary represented by a provider or supplier; and the ALJ

determines that the appellant had good cause for not producing the evidence earlier. [§ 405.1030\(c\)](#), [\(d\)](#).

- The appellant in a Part A or Part B appeal or the enrollee in a Part D appeal waives his or her right to appear at the hearing and subsequently withdraws his or her waiver. [§§ 405.1036\(b\)\(2\)](#), [423.2036\(b\)\(2\)](#). See [II-7](#) and [IV-7](#) for more information on waivers of the right to appear.
- The appellant waives the adjudication time frame. [§§ 405.1020\(I\)\(4\)](#), [405.1036\(d\)](#), [423.2036\(d\)](#). A waiver may be complete, which means no adjudication time frame applies, or the appellant may waive the adjudication period for a specific period of time agreed to by the ALJ and the appellant, which extends the adjudication time frame. See [I-7-3](#) for more information on waivers of the adjudication time frame.
- A party requests discovery from another party to the ALJ hearing ( the adjudication timeframe is tolled until the discovery dispute is resolved). [§§ 405.1016\(d\)](#), [405.1037\(f\)](#).
- A party in a Part A or Part B appeal or the enrollee in a Part D appeal requests a copy of all or part of the record and an opportunity to comment on the record. The time beginning with the ALJ's receipt of the request through expiration of the time granted for the party's response does not count towards the adjudication timeframe. [§§ 405.1042\(b\)\(2\)](#), [423.2042\(b\)\(2\)](#). See [II-4-7](#) and [IV-4-7](#) for more information on requests for copies of the administrative record.
- A Federal court stays the proceedings.

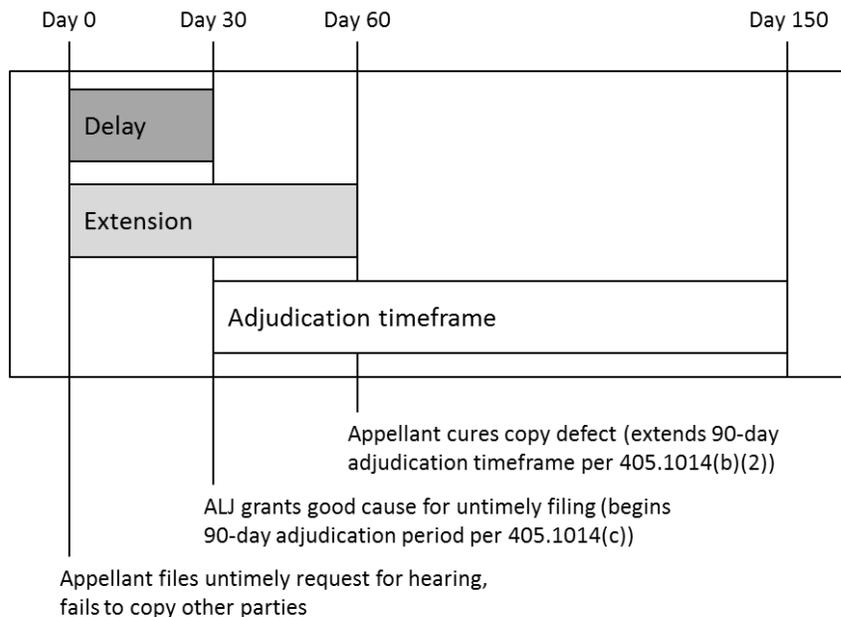
## **B. Concurrent/Overlapping Events**

If two or more events that delay the start of or extend the adjudication time frame occur during the same period of time, the adjustment to the adjudication time frame begins on the date the earlier event starts and ends on the date that all events have concluded. This ensures that each calendar day on which one or more events occurs counts only once in adjusting the adjudication time frame.

*Example.* An appellant in a Part A or Part B case files an untimely request for hearing and also fails to send a copy of the request for hearing to the other parties. Regardless of whether the party cures the failure to copy the other parties before or after the ALJ determines there is good cause to extend the time to file the request for hearing, the outcome is the same. Both events begin on the filing date, but the event that delays the beginning of the adjudication time frame (here, the untimely filing) may end before or after the event that extends the adjudication time frame (here, the failure to copy). The order of events affects the date on which the adjudication time frame begins and its duration,

though in both instances the end of the adjudication time frame is the same. This is illustrated in Figures 7.1 and 7.2 below.

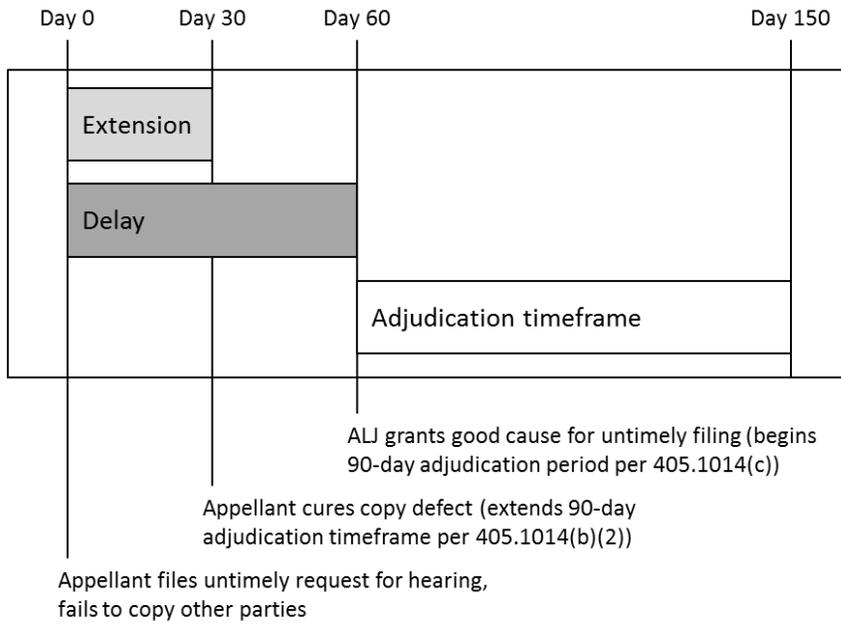
In **Figure 7.1**, the ALJ determines 30 days after the appellant files the request for hearing that the appellant had good cause for the untimely filing. Per §§ 405.1014(c) and 405.1016(b), the 90-day adjudication time frame begins on this date. However, the appellant does not cure the copy defect by sending the other parties a copy of its hearing request until day 60. The first 30 days of this event overlapped with the delay in starting the adjudication time frame due to the untimely filing, but the second 30 days of this event extends the 90-day adjudication time frame by 30 days. Because the adjudication time frame did not begin until day 30 due to the untimely filing, and the failure to copy the other parties extended the adjudication time frame an additional 30 days, the initial 90-day adjudication time frame ends 150 days after the appellant’s request for hearing was received.



**Figure 7.1** – Appellant cures copy defect *after* ALJ grants good cause for untimely filing

In **Figure 7.2**, the appellant cures the copy defect by sending the other parties a copy of its hearing request on day 30. However, the ALJ has not yet determined that the appellant had good cause for the untimely filing of the request for hearing, and does not do so until day 60. Per § 405.1014(c), the 90-day adjudication time frame does not begin until day 60. Because the appellant cured the copy defect before the start of the adjudication time frame, there is no extension applied. Nevertheless, the adjudication time frame still ends 150 days after the appellant’s request for hearing was received.

Division I: General Matters



**Figure 7.2** – Appellant cures copy defect *before* ALJ grants good cause for untimely filing.

### **I-7-3 Waivers of the Adjudication Time Frame**

Citations: §§ 405.1020, 405.1036(d); 405.1044(b), 423.2020, 423.2036(d); 423.2044

#### **A. Who May Waive an Adjudication Time Frame**

Only the appellant may waive the adjudication time frame.

- If multiple parties filed a request for hearing on the same claim, the filing parties are co-appellants, and each filing party must waive the adjudication time frame. An adjudication time frame waiver must be received from all appellants in order to waive the adjudication time frame for the case. A waiver by only one of the co-appellants has no effect on the adjudication time frame. Each appellant has an independent right to a decision, dismissal order, or remand order within the adjudication time frame.
- A non-appellant's waiver of the adjudication time frame has no effect on the adjudication time frame.

#### **B. Types and Effects of Adjudication Time Frame Waivers**

##### **1. Complete waiver.**

A complete waiver of the adjudication time frame means that no adjudication time frame applies to issuing a decision, dismissal order, or remand order. If escalation was available for the case, the appellant no longer has the right to escalate the case because there is no adjudication time frame.

##### **2. Waiver for a specific time period.**

A waiver of the adjudication time frame for a specific time period extends the time in which the adjudicator has to issue a decision, dismissal order, or remand order. The period of time must be specified as a number of calendar days. If escalation is available for the case, the appellant cannot escalate the case until the revised (extended) adjudication time frame has expired.

**NOTE:** Multiple waivers for a specific time frame may occur in a single case.

#### **C. Appellant-Initiated Adjudication Time Frame Waivers**

An appellant may waive the adjudication time frame on his or her own initiative at any time. The appellant may waive the adjudication time frame by:

1. Submitting a statement in writing that indicates he or she is waiving the adjudication time frame; or
2. Checking/completing item 5a or 5b on the Response to Notice of Hearing (form [HHS-729](#)).

**NOTE:** If the appellant submits a statement in writing in accordance with **C.1** above, that writing must be made part of the administrative record to document the waiver.

#### **D. Requesting an Adjudication Time Frame Waiver From an Appellant**

1. In very limited circumstances, the adjudicator may request a waiver of the adjudication time frame from an appellant when the appellant or a party to the case makes a procedural request that will delay the case or otherwise prevent the adjudicator from issuing a decision, dismissal order, or remand order within the applicable adjudication time frame. Examples of procedural requests that may give rise to a request by the adjudicator for an adjudication time frame waiver include:

- In accordance with [§ 405.1044\(b\)](#), the ALJ may require an appellant to waive the adjudication time frame associated with one or more cases if the appellant has requested consolidation of the cases and, in considering the appellant's request, the ALJ determines that consolidation otherwise prevents the ALJ from deciding all of the appeals at issue within their respective time frames.
- Before the hearing is scheduled, the appellant or another party requests a hearing date that will not allow sufficient time to conduct the hearing and issue a decision, dismissal order, or remand order within the applicable adjudication time frame.

**NOTE:** If the hearing has already been scheduled and the appellant requests the hearing be postponed, waiving the adjudication time frame is not necessary because the postponement is an event that extends the adjudication time frame.

[§ 405.1020\(h\)](#); [423.2020\(h\)](#).

- The appellant requests a delay in the case because a separate proceeding that could impact the case is pending (for example, a proceeding before the Departmental Appeals Board Civil Remedies Division on a Medicare provider/supplier exclusion or enrollment denial).
- The appellant needs additional time to gather information or evidence and no event that delays the start of or extends the adjudication time frame will apply.
- A co-appellant or non-appellant makes a procedural request that does not initiate an event that would extend the adjudication time frame and that request may delay

the case or otherwise prevent the adjudicator from issuing a decision, dismissal order or remand order within the adjudication time frame.

Examples of circumstances in which an adjudicator may not request an adjudication time frame waiver from the appellant are:

- The adjudicator may not be able to issue a decision, dismissal order, or remand order within the applicable time frame due to workload volume.
  - A hearing must be scheduled or rescheduled solely to accommodate the adjudicator's schedule, and the scheduled or rescheduled date and time will not allow sufficient time to conduct the hearing and issue a decision, dismissal order, or remand order within the applicable adjudication time frame.
2. In cases where the adjudicator may request a waiver, the adjudicator may suggest a waiver for a specific period of time or a complete waiver, based on the circumstances of the case and the nature of the request to be accommodated.
  3. If a party makes a procedural request that would result in the expiration of the time frame, the adjudicator may grant the request conditionally by requiring the appellant to waive the time frame for a specific period of time. This ensures sufficient time will be available to accommodate the appellant's procedural request while preserving the appellant's rights to a decision, dismissal order, or remand order within a specific period of time, to the extent practicable. However, this provision does not prevent the appellant from completely waiving the adjudication time frame to avoid the burden of filing additional waivers, if additional time becomes necessary.
  4. With the express approval of the Associate Chief Administrative Law Judge (ACALJ), an ALJ may initiate a discussion with the appellant concerning the potential for a voluntary waiver of the adjudication time frame when the circumstances of a case may not allow for a decision, dismissal order, or remand order to be issued within the adjudication time frame (for example, cases involving a substantial number of beneficiaries or statistical sampling, or cases in which scheduling of an in-person hearing makes issuing a decision within the time frame impracticable).

**NOTE:** When a voluntary waiver is discussed under this provision, the ALJ must emphasize that the appellant may limit the voluntary waiver to a specific period of time (for example, 30 additional days). However, this provision does not prevent the appellant from completely waiving the adjudication time frame to avoid filing additional waivers if additional time becomes necessary.

**E. Prohibition on Routine Waiver Requests or Pre-Selecting Waiver Indicators on Forms**

Routine waiver requests, routine issuance of adjudication time frame waiver forms, and pre-selecting waiver elections on forms are not permitted. Waiver requests may only be made in response to a procedural request from the appellant or another party to the case, when granting the procedural request could delay the case or otherwise prevent the adjudicator from issuing a decision, dismissal order, or remand order within the applicable adjudication time frame.

## **I-7-4 Adjudication Prioritization**

Citations: [§ 1879 of the Act](#); [§§ 405.906, 405.908, 405.910, 405.912, 405.970](#)

### **A. Generally**

OMHA's mission focuses on serving Medicare beneficiaries (including Part C and Part D enrollees) and timely adjudicating appeals. However, the number of appeal requests filed may prevent OMHA from achieving timeliness objectives. To mitigate the impact of the workload increase on adjudication times for individual Medicare beneficiaries and enrollees, OMHA has instituted a prioritization methodology to safeguard this population, while minimizing the impact on other appellants.

Prioritizing beneficiary-initiated cases allows OMHA to continue serving Medicare beneficiaries at the improved level of service that Congress intended in passing the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Moreover, given the relatively small number of beneficiary-initiated appeals, this prioritization does not significantly impact appeals initiated by Medicare providers and suppliers, Medicaid State agencies, and applicable plans against whom a MSP recovery is sought.

OMHA recognizes that in some instances, prioritizing beneficiary-initiated or enrollee-initiated cases may place these cases ahead of earlier filed requests that are subject to adjudication time frames. For example, prioritizing a Part C enrollee-initiated appeal may place that appeal ahead of a previously filed Part A provider-initiated appeal. However, this is an appropriate result given that these cases may concern pre-service requests such as prior authorization for services, or entitlement to benefits, and have a minimal impact on other appeals subject to an adjudication time frame given the comparatively small size of the priority workload. Moreover, certain types of decisions appealed by beneficiaries generally do not provide the beneficiary with any avenue for redress if the case is delayed. For example, there is no right to escalate a Part C enrollee-initiated appeal, or an entitlement or IRMAA beneficiary-initiated appeal. In contrast, most Medicare provider and supplier appeals, Medicaid State agency appeals, and applicable plan appeals arise from QIC reconsiderations, which allow the provider, supplier, or State agency to request escalation of an appeal after an adjudication time frame elapses.

## B. Levels of Priority

### 1. General Rule.

Requests for Hearing, Requests for Review, and escalated Requests for Reconsideration will generally be processed on a first in/first out basis within the following priority categories:

- Priority 1 (highest priority)
  - Part D expedited cases
  - Any other cases designated as Priority 1 by the Chief Administrative Law Judge
- Priority 2
  - Beneficiary-appellant or enrollee-appellant cases
- Priority 3
  - Medicaid State agency-appellant cases
  - Provider/supplier-appellant cases
  - Applicable plan-appellant cases involving a MSP recovery

### 2. Exception—Representatives.

If a beneficiary or enrollee is represented by another party with appeal rights, or a representative who also represents another party with appeal rights, the beneficiary's case is treated as a Priority 3 appeal, unless the beneficiary or enrollee is or would be liable for the costs (other than deductibles and co-insurance) of the items or services in dispute, or unless the case involves a pre-service request for coverage. This limitation includes the following circumstances:

- A beneficiary is represented by a provider or supplier that has independent appeal rights under [§ 405.906\(b\)](#);
- A beneficiary is represented by a Medicaid State agency that has independent appeal rights under [§§ 405.906\(b\)](#) and [405.908](#); or
- A beneficiary is represented by an individual or entity that also represents the provider, supplier, or Medicaid State agency involved in the case.

**NOTE:** [§ 405.910\(f\)\(3\)](#) requires that a provider or supplier that furnished the items or services to the beneficiary may not charge the beneficiary a fee for the representation and may not represent a beneficiary on an issue described in [§ 1879\(a\)\(2\) of the Act](#) unless the provider or supplier waives the right to payment from the beneficiary for the services or items involved in the appeal.

**3. Exception—Assignment of Appeal Rights.**

If a provider or supplier that furnished an item or service to the beneficiary and that is not already a party to the initial determination under § 405.906(b) has obtained an assignment of appeal rights from the beneficiary in accordance with § 405.912, the beneficiary is no longer a party, and the case is treated as a Priority 3 appeal.

**NOTE:** Appeals filed by providers and suppliers when there is no other party available under the provisions of § 405.906(c) are not subject to this exception

**4. Exception—Agreement to Waive Payment or Collection.**

If a beneficiary has been absolved of any responsibility for payment or collection of payment by the provider, supplier, Medicaid State agency, or a co-representative thereof, and the agreement is documented in the administrative record (including reports of contact with the beneficiary), the case is treated as a Priority 3 appeal. This limitation includes an agreement with a beneficiary to file an appeal request, directly or through a representative, with the objective of the appeal being prioritized when the beneficiary would not have otherwise filed an appeal request.

**C. Initiating and Docketing Cases**

OMHA Central Operations processes higher priority categories before lower priority categories for purposes of docketing and assignment. See II-2, III-2, IV-2 and V-2 for more information on docketing and assigning appeals.

## **D. Adjudicating Cases**

1. Field Office intake departments prioritize cases in the same manner as Central Operations and ensure higher priority level cases are forwarded to adjudication teams before lower priority level cases.
2. If all assigned cases cannot be decided within the adjudication time frames established by statute or regulation, adjudication teams prioritize assigned cases to meet timeliness objectives for higher priority level cases (for example, if timeliness objectives cannot be met for all three levels of cases, the adjudication teams prioritize work to achieve timeliness objectives for higher priority level cases, to the extent practicable).
3. Generally, cases within a priority level should be processed on a first-in/first-out basis. However, the assigned adjudicator has discretion to prioritize cases within a priority level based upon his or her review of the case, available resources, and the needs presented by the parties (for example, if the adjudicator has multiple beneficiary-initiated cases, the adjudicator may prioritize a later filed case if the case involves a pre-service authorization request).

## I-7-5 Escalations

Citations: [§§ 405.970, 405.1002, 405.1034, 405.1104, 405.1106,](#)

### A. Generally

Escalations are only available when authorized by statute. Requests for hearing or review may not be otherwise escalated or elevated to the Medicare Appeals Council by the motion of the parties or on the ALJ's own motion. Appeals for which escalation is not available because a QIC (as defined by [§ 1869 of the Act](#)) did not issue a decision or failed to issue a decision, include:

- All lower level dismissals subject to a request for review by an ALJ, including a request to review a QIC dismissal, even if filed using a request for hearing form;
- Part A and Part B eligibility or entitlement appeals from SSA reconsiderations;
- Part B and Part D IRMAA appeals from SSA reconsiderations;
- Part A and Part C appeals of QIO reconsiderations directly appealable to an ALJ;
- Part C appeals of Part C QIC reconsidered determinations;
- Part D appeals of Part D QIC reconsiderations; and
- Any decision that is not appealable to an ALJ (for example, a QIO's reconsideration of a coding change resulting from Diagnostic Related Group (DRG) validation under [§ 478.15](#)).

### B. Escalations from QIC to OMHA

#### 1. Generally.

For appeals eligible for escalation, the party that filed the request for a Part A or Part B QIC reconsideration may request escalation and a hearing before an ALJ when:

- a. The QIC did not issue a reconsideration within the adjudication time frame;
- b. The appellant notifies the QIC in writing that the appellant wishes to escalate the case; and
- c. The QIC is not able to issue a reconsideration or dismissal within 5 calendar days of receiving a notice that the appellant wishes to escalate its request for reconsideration (or 5 calendar days from the end of the applicable adjudication period).

[§1869\(c\)\(3\)\(C\); §§ 405.970\(e\) and 405.1002\(b\)](#).

The escalation request must be filed with the QIC with which the reconsideration is pending.

- If a request is mistakenly filed with OMHA, the request will be returned to the requesting party.

## **2. Reviewing cases escalated from the QIC.**

### **a. Generally**

Escalated cases received by OMHA are subject to a 180-day adjudication time frame, except when a certain event, defined in subsection **2.b**, below, extends or tolls it. The start of the 180-day adjudication time frame also can be delayed in certain circumstances, as defined below in subsection **2.c**. An appellant may request an escalation to the Medicare Appeals Council if the adjudication time frame is not met. §§ [405.1016\(c\)](#), [405.1104\(a\)](#).

### **b. Event that delays the start of the adjudication time frame.**

The only event that may delay the start of the adjudication time frame in an escalated case is if appellant files the request for hearing with an entity other than the entity specified in the QIC's or Part D QIC's reconsideration. §§ [405.1014\(b\)\(2\)](#), [423.2014\(c\)\(2\)\(i\)](#).

See [II-3-5 A-B](#) for additional information on timely filing.

### **c. Events that extend the adjudication time frame.**

The time frame for escalated cases received by OMHA may be extended for the same reasons defined in [I-7-2 A.2](#) above.

*Exception:* There is no requirement for the appellant to send a copy of the request for hearing to the other parties in escalated cases. The appellant is only subject to the copy requirement if the QIC issued a reconsideration decision. § [405.1014\(b\)\(2\)](#)

See [II-3-6 C](#) for more information on the copy requirement.

## **3. Remanding cases received on escalation from the QIC.**

### **a. Escalated in error.**

If a QIC escalates a request for reconsideration in error (for example, when a non-appellant requested the escalation, or where the matter appealed to the QIC was a request for a reconsideration of a contractor's dismissal of a redetermination request), the ALJ will remand the appeal to the QIC for information on the procedural basis for the escalation.

**b. The record is missing information.**

- i. If the missing information is not information that can be provided only by CMS or its contractors, the ALJ must retain jurisdiction of the case and obtain the information on his or her own, or directly from one of the parties.

[§ 405.1034\(a\)\(2\)](#).

- ii. Remands to the QIC to obtain missing information that is essential to resolving the issues on appeal and that can be provided only by CMS or its contractors should be avoided in cases OMHA received on escalation.

**NOTE:** “Can be provided only by CMS or its contractors” means the information is not publicly available and the information is not in the possession of, and cannot be requested and obtained by one of the parties. Information that is publicly available is information that is available to the general public via the Internet or in a printed publication. It includes, but is not limited to, information available on a CMS or contractor Web site or information in an official CMS or DHHS publication (including, but not limited to, provisions of NCDs or LCDs, procedure code or modifier descriptions, fee schedule data, and contractor operating manual instructions). [§ 405.1034\(a\)\(3\)](#).

- iii. If there is information essential to resolving the issue on appeal that can only be provided by CMS or its contractors, staff must first request that the contractor forward the missing information to the appropriate hearing office. Staff must document all steps taken to obtain the information and include form OMHA-101, Report of Contact, in the administrative record as necessary.
- iv. If staff is unable to obtain the missing information that can only be provided by CMS or its contractors after reasonable, documented attempts to directly contact the QIC, a remand may be issued.

**NOTE:** The information that is the subject of the remand issued under the authority of [§ 405.1034\(a\)\(i\)](#) cannot have the effect of requesting that the QIC conduct the reconsideration. For example, the ALJ may not issue a remand to obtain a medical review panel determination or a reconsideration decision.

**C. Escalations from OMHA to Medicare Appeals Council**

**1. Overview.**

- a. If OMHA does not issue a dismissal, remand or decision in a Part A or B appeal that is subject to the 90-day adjudication time frame and the appeal continues to be pending before the ALJ at the end of the applicable adjudication period, the

appellant may file a written request to escalate the appeal to the Medicare Appeals Council.

- If the request for hearing has been assigned to an ALJ, the written request to escalate is filed with the ALJ, at the ALJ's assigned field office.
- If the request for hearing is unassigned, the written request to escalate is filed with OMHA Central Operations.

**NOTE:** Appellants can verify whether they should file a request to escalate directly with the ALJ or with OMHA Central Operations by confirming the assignment status on the OMHA ALJ Appeal Status Information System (AASIS), available at: [http://www.hhs.gov/omha/Appeal\\_Status\\_Lookup/index.html](http://www.hhs.gov/omha/Appeal_Status_Lookup/index.html).

- b. If the ALJ is not able to issue a decision, dismissal order, or remand order within the later of 5 calendar days of receiving the request for escalation or 5 calendar days from the end of the applicable adjudication period, the ALJ sends notice to the appellant in accordance with § 405.1104(b), and the appellant may file a request for review with the Medicare Appeals Council, sending a copy of the request for review to the ALJ (or the OMHA Escalation Mail Stop if a case is unassigned), and meeting any other filing requirements applicable to a request for review by the Medicare Appeals Council. If the appellant does not file the request for review with the ALJ and the Medicare Appeals Council, the case will remain pending with the OMHA and continue to be processed.

## **2. Appeals that may be escalated.**

Escalation from OMHA to the Medicare Appeals Council is only available for:

- Requests for hearing on Part A and Part B QIC reconsiderations; and
- Requests for Part A or Part B QIC reconsiderations that were escalated to OMHA from the QIC.

**3. Filing a request to escalate with OMHA.**

- a. The request to escalate must be in writing. [§ 405.1104\(a\)\(1\)](#).
- b. The request may not be submitted until after the adjudication period has expired. [§ 405.1104\(a\)](#);
- c. The request to escalate may be submitted to the ALJ assigned to adjudicate the appellant's request for hearing or escalated request for QIC reconsideration, or to the OMHA Central Operations Escalation Mail Stop if the case is not yet assigned. [§ 405.1104\(a\)\(1\)](#); see also [II-1-2](#).
- d. The request must identify:
  - The party (or party's representative) requesting the escalation; and
  - The ALJ appeal number for which escalation is requested (the QIC Medicare appeal number may be used if the ALJ appeal number is not known).

**4. Processing the request to escalate.**

- a. The request to escalate must be date stamped with the business day that OMHA received the request.
- b. If the request was routed to the incorrect OMHA office, the request will be forwarded to the assigned ALJ or OMHA Central Operations (as applicable) no later than the next business day (using tracked mail, if mailed).
- c. The request to escalate must be entered into the administrative record and logged into the OMHA case management system.
- d. If the request to escalate does not: (1) identify a party (or representative) to the referenced appeal; and (2) identify an ALJ appeal number (or QIC Medicare appeal number) with which to associate the request, OMHA must advise the requestor in writing that the appeal cannot be escalated until this information is provided.
  - If the requestor provides the missing information and an appeal is identified, a copy of the filing and OMHA's response must be made part of the administrative record for any identified appeal.
  - If the requestor fails to provide the missing information or an appeal is not identified based on the information provided, the OMHA Hearing Office Director or Director of Central Operations must maintain a copy of the escalation request for a period of three years.

**5. Responding to the request to escalate.**

- a. If the request to escalate is valid, one of the following actions must be taken within 5 calendar days of receiving the request, or 5 calendar days from the end of the adjudication time frame, whichever occurs later:
  - The ALJ issues a decision, dismissal order, or remand order, in accordance with standard procedures for the case ([§ 405.1104\(a\)](#)); or
  - The ALJ (or OMHA Central Operations, if the appeal is unassigned) issues OMHA-385, Acknowledgment of Request to Escalate, acknowledging receipt of the request to escalate and confirming that the ALJ (or OMHA Central Operations, if the appeal is unassigned) is not able to issue a decision, dismissal, or remand within the applicable adjudication time frame. [§ 405.1104\(b\)](#). The acknowledgement conveys the next steps in the escalation process. The appeal remains pending with OMHA and the case is processed in accordance with standard procedures, unless the appellant seeks Medicare Appeals Council review. [§ 405.1104\(c\)](#).
- b. If the request to escalate is not valid, the ALJ or OMHA will issue OMHA-386 Notice of Invalid Escalation Request within 5 calendar days of receiving the request for escalation, providing notice to the requesting party that the request to escalate is denied and the reason(s) for the denial. The appeal remains pending with OMHA and the case is processed in accordance with standard procedures. The party may attempt to cure any identified procedural defects by submitting a new request to escalate.

**6. Failure to respond.**

If OMHA fails to respond to a request to escalate in one of the manners described above, the requesting party may proceed with the escalation process by requesting Medicare Appeals Council review. [§ 405.1104\(b\)\(3\)](#).

**7. Request for Medicare Appeals Council review.**

**a. Completing the escalation process.**

The appellant is responsible for requesting Medicare Appeals Council review after submitting a request to escalate to OMHA and receiving a response from OMHA (or not receiving a response after the time for OMHA to respond has elapsed). The request for escalation must be filed with both the Medicare Appeals Council and OMHA, and a copy of the request for escalation must be sent to the other parties. [§ 405.1106\(b\)](#).

**b. Receipt of a request for Medicare Appeals Council review from the appellant.**

OMHA will take no further action on the appeal until the Medicare Appeals Council requests the record or notice is received from the Medicare Appeals Council that the request for review has been dismissed or not received.

- The request for Medicare Appeals Council review must be added to the administrative record.
- ALJ staff must inform the Hearing Office Director (for assigned cases) or Director of Central Operations (for unassigned cases), or their designees, if: (1) a decision, dismissal order, or remand order was issued by an OMHA adjudicator in the case; (2) the request to escalate was dismissed or could not be processed; or (3) OMHA has no record of receiving a request to escalate. The Hearing Office Director or Central Operations Director, or their designees, are responsible for relaying the information and any supporting documentation to the Director of Field Operations, or his or her designee.

**c. Medicare Appeals Council request for the administrative record.**

OMHA must furnish to the Medicare Appeals Council the complete administrative record, including the records received from the QIC and all documentation submitted to and issued by OMHA within 5 calendar days of the request for the administrative record. See II-13-1 C for more information.

- If OMHA has not requested the records from the QIC by the time the Medicare Appeals Council requests the record, OMHA must request the QIC records and combine these materials with the request for hearing or escalation of the request for QIC reconsideration, and all other materials submitted to or issued by OMHA.
- If record materials are not or will not be available within 5 calendar days of the request from the Medicare Appeals Council, OMHA must send the available records to the Medicare Appeals Council in accordance with operational agreements.
- OMHA must forward any materials that were not available at the time the available records were shipped to the Medicare Appeals Council within two business days of when the materials become available, in accordance with operational agreements.
- When OMHA sends the available records to the Medicare Appeals Council pursuant to its request, OMHA closes the appeal with a disposition of escalation

without further notice to the parties. All other closing procedures apply. See II-13 for more information on closing the case.

**d. Medicare Appeals Council dismisses request for escalation or notifies OMHA that no request for review was received.**

If the Medicare Appeals Council dismisses a request for escalation, or notifies OMHA that no request for review was received, OMHA resumes standard processing procedures for the appeal, and any materials sent to OMHA by the Medicare Appeals Council related to the appeal are added to the administrative record.

**D. No Escalation Requested**

If escalation is available, but the appellant does not request escalation, the case remains with and is adjudicated by the ALJ in accordance with normal case processing procedures.