(iii) The ALJ determines that the appeals the enrollees seek to aggregate involve the same prescriptiion.

§ 423.1972 Request for an ALJ hearing.

(a) *How and where to file a request.* The enrollee must file a written request for a hearing with the entity specified in the IRE's reconsideration notice.

(b) *When to file a request.* Except when an ALJ extends the timeframe as provided in § 423.2014(d), the enrollee must file a request for a hearing within 60 calendar days of the date of the notice of an IRE reconsideration determination. The time and place for a hearing before an ALJ will be set in accordance with § 423.2020 of this chapter.

(c) *Insufficient amount in controversy.* (1) If a request for a hearing clearly shows that the amount in controversy is less than that required under § 423.1970, the ALJ dismisses the request.

(2) If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than the amount required under § 423.1970, the ALJ discontinues the hearing and does not rule on the substantive issues raised in the appeal.

§ 423.1974 Medicare Appeals Council (MAC) review.

An enrollee who is dissatisfied with an ALJ hearing decision may request that the MAC review the ALJ's decision or dismissal as provided in § 423.2102.

§ 423.1976 Judicial review.

(a) *Review of ALJ's decision.* The enrollee may request judicial review of an ALJ's decision if—

(1) The MAC denied the enrollee's request for review; and

(2) The amount in controversy meets the threshold requirement established annually by the Secretary.

(b) *Review of MAC decision.* The enrollee may request judicial review of the MAC decision if it is the final decision of CMS and the amount in controversy meets the threshold established in paragraph (a)(2) of this section.

(c) *How to request judicial review.* In order to request judicial review, an enrollee must file a civil action in a district court of the United States in accordance with section 205(g) of the Act. (See § 423.2136 for a description of the procedures to follow in requesting judicial review.)

§ 423.1978 Reopening determinations and decisions.

(a) A coverage determination or redetermination made by a Part D plan sponsor, a reconsideration made by the independent review entity specified in § 423.600, or the decision of an ALJ or the MAC that is otherwise binding may be reopened and revised by the entity that made the determination or decision as provided in § 423.1980 through § 423.1986.

(b) The filing of a request for reopening does not relieve the Part D plan sponsor of its obligation to make payment or provide benefits as specified in § 423.636 or § 423.638 of this chapter.

(c) Once an entity issues a revised determination or decision, the revisions made by the decision may be appealed.

(d) A decision not to reopen by the Part D plan sponsor or any other entity is not subject to review.

§ 423.1980 Reopenings of coverage determinations, redeterminations, reconsiderations, hearings and reviews.

(a) *General rules.* (1) A reopening is a remedial action taken to change a binding determination or decision, even though the binding determination or decision may have been correct at the time it was made based on the evidence of record. Consistent with § 423.1978(a), that action may be taken by—

(i) A Part D plan sponsor to revise the coverage determination or redetermination;

(ii) An IRE to revise the reconsideration;

(iii) An ALJ to revise the hearing decision; or

(iv) The MAC to revise the hearing or review decision.

(2) When an enrollee has filed a valid request for an appeal of a coverage determination, redetermination, reconsideration, hearing, or MAC review, no adjudicator has jurisdiction to reopen an issue that is under appeal until all