

§ 405.978

1862(a)(1)(A) of the Act, an explanation of the medical and scientific rationale for the decision;

(5) A summary of the rationale for the reconsideration.

(i) If the notice of redetermination indicated that specific documentation should be submitted with the reconsideration request, and the documentation was not submitted with the request for reconsideration, the summary must indicate how the missing documentation affected the reconsideration; and

(ii) The summary must also specify that, consistent with §§ 405.956(b)(8) and 405.966(b), all evidence, including evidence requested in the notice of redetermination, that is not submitted prior to the issuance of the reconsideration will not be considered at the OMHA level, unless the appellant demonstrates good cause as to why the evidence was not provided prior to the issuance of the QIC's reconsideration. This requirement does not apply to beneficiaries, unless the beneficiary is represented by a provider or supplier or to State Medicaid Agencies;

(6) Information concerning to the parties' right to an ALJ hearing, including the applicable amount in controversy requirement and aggregation provisions;

(7) A statement of whether the amount in controversy is estimated to meet or not meet the amount required for an ALJ hearing, if—

(i) The request for reconsideration was filed by a beneficiary who is not represented by a provider, supplier, or Medicaid State agency; and

(ii) The reconsideration decision is partially or fully unfavorable.

(8) A description of the procedures that a party must follow in order to obtain an ALJ hearing of an expedited reconsideration, including the time frame under which a request for an ALJ hearing must be filed;

(9) If appropriate, advice as to the requirements for use of the expedited access to judicial review process set forth in § 405.990;

(10) The procedures for obtaining additional information concerning the reconsideration, such as specific provisions of the policy, manual, or regula-

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tion used in making the reconsideration; and

(11) Any other requirements specified by CMS.

[70 FR 11472, Mar. 8, 2005, as amended at 82 FR 5108, Jan. 17, 2017]

§ 405.978 Effect of a reconsideration.

A reconsideration is binding on all parties, unless—

(a) An ALJ or attorney adjudicator decision is issued in accordance to a request for an ALJ hearing made in accordance with § 405.1014;

(b) A review entity issues a decision in accordance to a request for expedited access to judicial review under § 405.990; or

(c) The reconsideration is revised as a result of a reopening in accordance with § 405.980.

[70 FR 11472, Mar. 8, 2005, as amended at 74 FR 65334, Dec. 9, 2009; 82 FR 5108, Jan. 17, 2017]

REOPENINGS

§ 405.980 Reopening of initial determinations, redeterminations, reconsiderations, decisions, and reviews.

(a) *General rules.* (1) A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or underpayment, even though the binding determination or decision may have been correct at the time it was made based on the evidence of record. That action may be taken by—

(i) A contractor to revise the initial determination or redetermination;

(ii) A QIC to revise the reconsideration;

(iii) An ALJ or attorney adjudicator to revise his or her decision; or

(iv) The Council to revise the ALJ or attorney adjudicator decision, or its review decision.

(2) If a contractor issues a denial of a claim because it did not receive requested documentation during medical review and the party subsequently requests a redetermination, the contractor must process the request as a reopening.

(3) Notwithstanding paragraph (a)(4) of this section, a contractor must process clerical errors (which includes