

(3) An enrollee who received a Council decision or a Part D plan sponsor may request that the Council reopen its decision within 180 calendar days from the date of the review decision for good cause in accordance with § 423.1986.

[74 FR 65363, Dec. 9, 2009, as amended at 82 FR 5126, Jan. 17, 2017]

§ 423.1982 Notice of a revised determination or decision.

(a) *When adjudicators initiate reopenings.* When any determination or decision is reopened and revised as provided in § 423.1980:

(1) The Part D plan sponsor, IRE, ALJ or attorney adjudicator, or the Council must mail its revised determination or decision to the enrollee at his or her last known address.

(2) The IRE, ALJ or attorney adjudicator, or the Council must mail its revised determination or decision to the Part D plan sponsor.

(3) An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal.

(b) *Reopenings initiated at the request of an enrollee or a Part D plan sponsor.*

(1) The Part D plan sponsor, IRE, ALJ or attorney adjudicator, or the Council must mail its revised determination or decision to the enrollee at his or her last known address.

(2) The IRE, ALJ or attorney adjudicator or the Council must mail its revised determination or decision to the Part D plan sponsor.

(3) An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal.

[74 FR 65363, Dec. 9, 2009, as amended at 82 FR 5126, Jan. 17, 2017]

§ 423.1984 Effect of a revised determination or decision.

(a) *Coverage determinations.* The revision of a coverage determination is binding unless an enrollee submits a request for a redetermination that is accepted and processed in accordance with § 423.580 through § 423.590.

(b) *Redeterminations.* The revision of a redetermination is binding unless an enrollee submits a request for an IRE reconsideration that is accepted and

processed in accordance with § 423.600 through § 423.604.

(c) *Reconsiderations.* The revision of a reconsideration is binding unless an enrollee submits a request for an ALJ hearing that is accepted and processed in accordance with §§ 423.2000 through 423.2063.

(d) *ALJ or attorney adjudicator decisions.* The revision of an ALJ or attorney adjudicator decision is binding unless an enrollee submits a request for a Council review that is accepted and processed as specified in §§ 423.2100 through 423.2130.

(e) *Council review.* The revision of a Council determination or decision is binding unless an enrollee files a civil action in which a Federal District Court accepts jurisdiction and issues a decision.

(f) *Appeal of only the portion of the determination or decision revised by the reopening.* Only the portion of the coverage determination, redetermination, reconsideration, or hearing decision revised by the reopening may be subsequently appealed.

(g) *Effect of a revised determination or decision.* Consistent with § 423.1978(c), a revised determination or decision is binding unless it is appealed or otherwise reopened.

[74 FR 65363, Dec. 9, 2009, as amended at 82 FR 5127, Jan. 17, 2017; 84 FR 19872, May 7, 2019]

§ 423.1986 Good cause for reopening.

(a) *Establishing good cause.* Good cause may be established when—

(1) There is new and material evidence that—

(i) Was not available or known at the time of the determination or decision; and

(ii) May result in a different conclusion; or

(2) The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

(b) *Change in substantive law or interpretative policy.* (1) *General rule.* A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent

§ 423.1990

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or otherwise, is not a basis for reopening a determination or hearing decision regarding appeals under this section.

(2) An adjudicator may reopen a determination or decision to apply the current law or CMS or the Part D plan sponsor policy rather than the law or CMS or the Part D plan sponsor policy at the time the coverage determination is made in situations where the enrollee has not yet received the drug and the current law or CMS or the Part D plan sponsor policy may affect whether the drug should be received.

(c) *Third party payer error.* A request to reopen a claim based upon a third party payer's error in making a primary payment determination when Medicare processed the claim in accordance with the information in its system of records or on the claim form does not constitute good cause for reopening.

§ 423.1990 Expedited access to judicial review.

(a) *Process for expedited access to judicial review.* (1) For purposes of this section, a “review entity” means an entity of up to three reviewers who are ALJs or members of the Departmental Appeals Board, as determined by the Secretary.

(2) In order to obtain expedited access to judicial review (EAJR), a review entity must certify that the Council does not have the authority to decide the question of law or regulation relevant to the matters in dispute and that there is no material issue of fact in dispute.

(3) An enrollee may make a request for EAJR only once with respect to a question of law or regulation for a specific matter in dispute in an appeal.

(b) *Conditions for making the expedited appeals request.* (1) An enrollee may request EAJR in place of an ALJ hearing or Council review if the following conditions are met:

(i) An IRE has made a reconsideration determination and the enrollee has filed a request for an ALJ hearing in accordance with § 423.2002 and a decision, dismissal order, or remand order of the ALJ or an attorney adjudicator has not been issued; or

(ii) An ALJ or attorney adjudicator has made a decision and the enrollee

has filed a request for Council review in accordance with § 423.2102 and a final decision, dismissal order, or remand order of the Council has not been issued.

(2) The requestor is an enrollee.

(3) The amount remaining in controversy meets the threshold requirements specified in § 423.2006.

(4) If there is more than one enrollee to the hearing or Council review, each enrollee concurs, in writing, with the request for the EAJR.

(5) There are no material issues of fact in dispute.

(c) *Content of the request for EAJR.* The request for EAJR must—

(1) Allege that there are no material issues of fact in dispute and identify the facts that the enrollee considers material and that are not disputed; and

(2) Assert that the only factor precluding a decision favorable to the enrollee is—

(i) A statutory provision that is unconstitutional, or a provision of a regulation that is invalid and specify the statutory provision that the enrollee considers unconstitutional or the provision of a regulation that the enrollee considers invalid; or

(ii) A CMS Ruling that the enrollee considers invalid.

(3) Include a copy of the IRE reconsideration and of any ALJ or attorney adjudicator decision that the enrollee has received;

(4) If the IRE reconsideration or ALJ or attorney adjudicator decision was based on facts that the enrollee is disputing, state why the enrollee considers those facts to be immaterial; and

(5) If the IRE reconsideration or ALJ or attorney adjudicator decision was based on a provision of a law, regulation, or CMS Ruling in addition to the one the enrollee considers unconstitutional or invalid, a statement as to why further administrative review of how that provision applies to the facts is not necessary.

(d) *Place and time for an EAJR request.*

(1) *Method and place for filing request.* The enrollee may—

(i) If a request for ALJ hearing or Council review is not pending, file a written EAJR request with the HHS Departmental Appeals Board, with his