

the IRE, or its successor, to readjudicate the request for reconsideration, unless the request for redetermination was forwarded to the IRE in accordance with § 423.590(c) or (e) without a redetermination having been conducted.

(c) *Requested remand*—(1) *Request contents and timing*. At any time prior to an ALJ or attorney adjudicator issuing a decision or dismissal, the enrollee and CMS, the IRE, or the Part D plan sponsor may jointly request a remand of the appeal to the IRE. The request must include the reasons why the appeal should be remanded, and indicate whether remanding the case will likely resolve the matter in dispute.

(2) *Granting the request*. An ALJ or attorney adjudicator may grant the request and issue a remand if he or she determines that remanding the case will likely resolve the matter in dispute.

(d) *Remanding an IRE's dismissal of a request for reconsideration*. (1) Consistent with § 423.2004(b), an ALJ or attorney adjudicator will remand a case to the appropriate IRE if the ALJ or attorney adjudicator determines that an IRE's dismissal of a request for reconsideration was in error.

(2) If an official copy of the notice of dismissal or case file cannot be obtained from the IRE, an ALJ or attorney adjudicator may also remand a request for review of a dismissal in accordance with the procedures in paragraph (a) of this section.

(e) *Consideration of change in condition*. The ALJ or attorney adjudicator will remand a case to the appropriate IRE if the ALJ or attorney adjudicator determines that the enrollee wants evidence on his or her change in condition after the coverage determination or at-risk determination to be considered in the appeal.

(f) *Notice of a remand*. OMHA mails or otherwise transmits a written notice of the remand of the request for hearing or request for review to the enrollee at his or her last known address, and CMS, the IRE, and/or the Part D plan sponsor if a request to be a participant was granted by the ALJ or attorney adjudicator. The notice states that there is a right to request that the Chief ALJ or a designee review the remand, unless

the remand was issued under paragraph (d)(1) of this section.

(g) *Review of remand*. Upon a request by the enrollee or CMS, the IRE, or the Part D plan sponsor filed within 30 calendar days of receiving a notice of remand, the Chief ALJ or designee will review the remand, and if the remand is not authorized by this section, vacate the remand order. The determination on a request to review a remand order is binding and not subject to further review. The review of remand procedures provided for in this paragraph (g) are not available for and do not apply to remands that are issued in paragraph (d)(1) of this section.

[82 FR 5136, Jan. 17, 2017, as amended at 83 FR 16754, Apr. 16, 2018; 84 FR 19873, May 7, 2019]

§ 423.2058 Effect of a remand.

A remand of a request for hearing or request for review is binding unless vacated by the Chief ALJ or a designee in accordance with § 423.2056(g).

[82 FR 5137, Jan. 17, 2017]

§ 423.2062 Applicability of policies not binding on the ALJ and Council.

(a) ALJs or attorney adjudicators and the Council are not bound by CMS program guidance, such as program memoranda and manual instructions, but will give substantial deference to these policies if they are applicable to a particular case.

(b) If an ALJ or attorney adjudicator or Council declines to follow a policy in a particular case, the ALJ or attorney adjudicator or Council decision must explain the reasons why the policy was not followed. An ALJ or attorney adjudicator or Council decision to disregard a policy applies only to the specific coverage determination or at-risk determination being considered and does not have precedential effect.

[74 FR 65363, Dec. 9, 2009, as amended at 82 FR 5137, Jan. 17, 2017; 83 FR 16754, Apr. 16, 2018]

§ 423.2063 Applicability of laws, regulations, CMS Rulings, and precedential decisions.

(a) All laws and regulations pertaining to the Medicare program, including, but not limited to Titles XI,

XVIII, and XIX of the Social Security Act and applicable implementing regulations, are binding on ALJs and attorney adjudicators, and the Council.

(b) CMS Rulings are published under the authority of the CMS Administrator. Consistent with § 401.108 of this chapter, rulings are binding on all CMS components, and on all HHS components that adjudicate matters under the jurisdiction of CMS.

(c) Precedential decisions designated by the Chair of the Departmental Appeals Board in accordance with § 401.109 of this chapter are binding on all CMS components, and all HHS components that adjudicate matters under the jurisdiction of CMS.

[82 FR 5137, Jan. 17, 2017]

§ 423.2100 Medicare Appeals Council review: general.

(a) An enrollee who is dissatisfied with an ALJ's or attorney adjudicator's decision or dismissal may request that the Council review the ALJ's or attorney adjudicator's decision or dismissal.

(b) When the Council reviews an ALJ's or attorney adjudicator's written decision, it undertakes a de novo review.

(c) The Council issues a final decision, dismissal order, or remands a case to the ALJ or attorney adjudicator no later than the end of the 90 calendar day period beginning on the date the request for review is received (by the entity specified in the ALJ's or attorney adjudicator's written notice of decision), unless the 90 calendar day period is extended as provided in this subpart or the enrollee requests expedited Council review.

(d) If an enrollee requests expedited Council review, the Council issues a final decision, dismissal order or remand as expeditiously as the enrollee's health condition requires, but no later than the end of the 10 calendar day period beginning on the date the request for review is received (by the entity specified in the ALJ's or attorney adjudicator's written notice of decision), unless the 10 calendar day period is extended as provided in this subpart.

[82 FR 5137, Jan. 17, 2017, as amended at 84 FR 19874, May 7, 2019]

§ 423.2102 Request for Council review when ALJ or attorney adjudicator issues decision or dismissal.

(a)(1) An enrollee may request Council review of a decision or dismissal issued by an ALJ or attorney adjudicator if the enrollee files a written request for a Council review within 60 calendar days after receipt of the ALJ's or attorney adjudicator's written decision or dismissal.

(2) An enrollee may request that Council review be expedited if the appeal involves an issue specified in § 423.566(b) but does not include solely a request for payment of Part D drugs already furnished.

(i) If an enrollee is requesting that the Council review be expedited, the enrollee submits an oral or written request within 60 calendar days after the receipt of the ALJ's or attorney adjudicator's written decision or dismissal. A prescribing physician or other prescriber may provide oral or written support for an enrollee's request for expedited review.

(ii) The Council must document all oral requests for expedited review in writing and maintain the documentation in the case files.

(3) For purposes of this section, the date of receipt of the ALJ's or attorney adjudicator's written decision or dismissal is presumed to be 5 calendar days after the date of the notice of the decision or dismissal, unless there is evidence to the contrary.

(4) The request is considered as filed on the date it is received by the entity specified in the notice of the ALJ's or attorney adjudicator's action.

(b) An enrollee requesting a review may ask that the time for filing a request for Council review be extended if—

(1) The request for an extension of time is in writing or, for expedited reviews, in writing or oral. The Council must document all oral requests in writing and maintain the documentation in the case file.

(2) The request explains why the request for review was not filed within the stated time period. If the Council finds that there is good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, the Council uses the