

In an overpayment case involving multiple beneficiaries who have no liability, the QIC may issue a written notice only to the appellant.

(b) *Content of the notice.* The reconsideration must be in writing and contain—

(1) A clear statement indicating whether the reconsideration is favorable or unfavorable;

(2) A summary of the facts, including as appropriate, a summary of the clinical or scientific evidence used in making the reconsideration;

(3) An explanation of how pertinent laws, regulations, coverage rules, and CMS policies, apply to the facts of the case, including, where applicable, the rationale for declining to follow an LCD, LMRP, or CMS program guidance;

(4) In the case of a determination on whether an item or service is reasonable or necessary under section 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 regulation 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 minor errors and omissions) as reopenings, instead of as redeterminations as specified in § 405.940. If the contractor receives a request for reopening and disagrees that the issue is a clerical error, the contractor must dismiss the reopening request and advise the party of any appeal rights, provided the timeframe to request an appeal on the original denial has not expired. For purposes of this section, clerical error includes human or mechanical errors on the part of the party or the contractor such as—

- (i) Mathematical or computational mistakes;
- (ii) Inaccurate data entry; or
- (iii) Denials of claims as duplicates.

(4) When a party has filed a valid request for an appeal of an initial determination, redetermination, reconsideration, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen an issue on a claim that is under appeal until all appeal rights for that issue are exhausted. Once the appeal rights for the issue have been exhausted, the contractor, QIC, ALJ or attorney adjudicator, or Council may reopen as set forth in this section.

(5) The contractor's, QIC's, ALJ's or attorney adjudicator's, or Council's decision on whether to reopen is binding and not subject to appeal.

(6) A determination under the Medicare secondary payer provisions of section 1862(b) of the Act that Medicare has an MSP recovery claim for services or items that were already reimbursed by the Medicare program is not a reopening, except where the recovery claim is based upon a provider's or supplier's failure to demonstrate that it filed a proper claim as defined in part 411 of this chapter.

(b) *Time frames and requirements for reopening initial determinations and redeterminations initiated by a contractor.* A contractor may reopen an initial determination or redetermination on its own motion—

(1) Within 1 year from the date of the initial determination or redetermination for any reason.

(2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.

(3) At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.

(4) At anytime if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

(5) At any time to effectuate a decision issued under the coverage appeals process.

(c) *Time frame and requirements for reopening initial determinations and redeterminations requested by a party.* (1) A party may request that a contractor reopen its initial determination or redetermination within 1 year from the date of the initial determination or redetermination for any reason.

(2) A party may request that a contractor reopen its initial determination or redetermination within 4 years from the date of the initial determination or redetermination for good cause in accordance with § 405.986.

(3) A party may request that a contractor reopen its initial determination at any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

Third party payer error does not constitute clerical error. See § 405.986(c).

(4) A party may request that a contractor reopen an initial determination for the purpose of reporting and returning an overpayment under § 401.305 of this chapter.

(d) *Time frame and requirements for reopening reconsiderations, decisions and reviews initiated by a QIC, ALJ or attorney adjudicator, or the Council.* (1) A QIC may reopen its reconsideration on its own motion within 180 calendar days from the date of the reconsideration for good cause in accordance with § 405.986. If the QIC's reconsideration was procured by fraud or similar fault, then the QIC may reopen at any time.

(2) An ALJ or attorney adjudicator may reopen his or her decision, or the Council may reopen an ALJ or attorney adjudicator decision on its own motion within 180 calendar days from the date of the decision for good cause in accordance with § 405.986. If the decision was procured by fraud or similar fault, then the ALJ or attorney adjudicator may reopen his or her decision, or the Council may reopen an ALJ or attorney adjudicator decision, at any time.

(3) The Council may reopen its review decision on its own motion within 180 calendar days from the date of the review decision for good cause in accordance with § 405.986. If the Council's decision was procured by fraud or similar fault, then the Council may reopen at any time.

(e) *Time frames and requirements for reopening reconsiderations, decisions, and reviews requested by a party.* (1) A party to a reconsideration may request that a QIC reopen its reconsideration within 180 calendar days from the date of the reconsideration for good cause in accordance with § 405.986.

(2) A party to an ALJ or attorney adjudicator decision may request that an ALJ or attorney adjudicator reopen his or her decision, or the Council reopen an ALJ or attorney adjudicator decision, within 180 calendar days from the date of the decision for good cause in accordance with § 405.986.

(3) A party to a Council review 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 § 405.986.

[70 FR 11472, Mar. 8, 2005, as amended at 70 FR 37703, June 30, 2005; 74 FR 65334, Dec. 9, 2009; 81 FR 7684, Feb. 12, 2016; 82 FR 5108, Jan. 17, 2017]

§ 405.982 Notice of a revised determination or decision.

(a) *When adjudicators initiate reopenings.* When any determination or decision is reopened and revised as provided in § 405.980, the contractor, QIC, ALJ or attorney adjudicator, or the Council must mail its revised determination or decision to the parties to that determination or decision at their last known address. In the case of a full or partial reversal resulting in issuance of a payment to a provider or supplier, a revised electronic or paper remittance advice notice must be issued by the Medicare contractor. 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 a party.* The contractor, QIC, ALJ or attorney adjudicator, or the Council must mail its revised determination or decision to the parties to that determination or decision at their last known address. In the case of a full or partial reversal resulting in issuance of a payment to a provider or supplier, a revised electronic or paper remittance advice notice must be issued by the Medicare contractor. An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal.

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

§ 405.984 Effect of a revised determination or decision.

(a) *Initial determinations.* The revision of an initial determination is binding upon all parties unless a party files a written request for a redetermination that is accepted and processed in accordance with § 405.940 through § 405.958.

(b) *Redeterminations.* The revision of a redetermination is binding upon all parties unless a party files a written request for a QIC reconsideration that