

(9) The procedures for obtaining additional information concerning the redetermination, such as specific provisions of the policy, manual, or regulation used in making the redetermination.

(10) Any other requirements specified by CMS.

(c) *Content of the notice for a full reversal.* For decisions that are full reversals of the initial determination, the redetermination must be in writing and contain—

(1) A clear statement indicating that the redetermination is wholly favorable;

(2) Any other requirements specified by CMS.

(d) *Exception for beneficiary appeal requests.* (1) The notice must inform beneficiary appellants that the requirements of paragraph (b)(8) of this section are not applicable for purposes of beneficiary appeals.

(2) This exception does not apply for appeal requests from beneficiaries who are represented by providers or suppliers.

**§ 405.958 Effect of a redetermination.**

In accordance with section 1869 (a)(3)(D) of the Act, once a redetermination is issued, it becomes part of the initial determination. The redetermination is final and binding upon all parties unless—

(a) A reconsideration is completed in accordance with § 405.960 through § 405.978; or

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

RECONSIDERATION

**§ 405.960 Right to a reconsideration.**

A person or entity that is a party to a redetermination made by a contractor as described under § 405.940 through § 405.958, and is dissatisfied with that determination, may request a reconsideration by a QIC in accordance with § 405.962 through § 405.966, regardless of the amount in controversy.

**§ 405.962 Timeframe for filing a request for a reconsideration.**

(a) *Timeframe for filing a request.* Except as provided in paragraph (b) of

this section, any request for a reconsideration must be filed within 180 calendar days from the date the party receives the notice of the redetermination.

(1) For purposes of this section, the date of receipt of the redetermination will be presumed to be 5 days after the date of the notice of redetermination, unless there is evidence to the contrary.

(2) For purposes of meeting the 180-day filing deadline, the request is considered as filed on the date it is received by the QIC.

(b) *Extending the time for filing a request—*(1) *General rule.* A QIC may extend the 180-day timeframe for filing a request for reconsideration for good cause.

(2) *How to request an extension.* A party to the redetermination must file its request for an extension of the time for filing the reconsideration request with its request for reconsideration. A party should include evidence to support the request for extension. The request for reconsideration and request for extension must—

(i) Be in writing;

(ii) State why the request for reconsideration was not filed within the required timeframe; and

(iii) Meet the requirements of § 405.964.

(3) *How the QIC determines whether good cause exists.* In determining whether a party has good cause for missing a deadline to request reconsideration, the QIC applies the good cause provisions contained in § 405.942(b)(2) and (b)(3).

**§ 405.964 Place and method of filing a request for a reconsideration.**

(a) *Filing location.* The request for reconsideration must be filed with the QIC indicated on the notice of redetermination.

(b) *Content of reconsideration request.* The request for reconsideration must be in writing and should be made on a standard CMS form. A written request that is not made on a standard CMS form is accepted if it contains the same required elements, as follows:

(1) The beneficiary's name;

(2) Medicare health insurance claim number;

(3) Specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;

(4) The name and signature of the party or the representative of the party; and

(5) The name of the contractor that made the redetermination.

(c) *Requests for reconsideration by more than one party.* If more than one party timely files a request for reconsideration on the same claim before a reconsideration is made on the first timely filed request, the QIC must consolidate the separate requests into one proceeding and issue one reconsideration.

**§ 405.966 Evidence to be submitted with the reconsideration request.**

(a) *Evidence submitted with the request.* When filing a request for reconsideration, a party should present evidence and allegations of fact or law related to the issue in dispute and explain why it disagrees with the initial determination, including the redetermination.

(1) This evidence must include any missing documentation identified in the notice of redetermination, consistent with § 405.956(b)(6).

(2) Absent good cause, failure to submit all evidence, including documentation requested in the notice of redetermination prior to the issuance of the notice of reconsideration precludes subsequent consideration of that evidence.

(b) *Evidence submitted after the request.* Each time a party submits additional evidence after filing the request for reconsideration, the QIC's 60-day decisionmaking timeframe is automatically extended by up to 14 calendar days for each submission. This extension does not apply to timely submissions of documentation specifically requested by a QIC, unless the documentation was originally requested in the notice of redetermination.

(c) *Exception for beneficiaries and State Medicaid Agencies that file reconsideration requests.* (1) Beneficiaries and State Medicaid Agencies that file requests for reconsideration are not required to comply with the requirements of paragraph (a) of this section. However, the automatic 14-day extension described in paragraph (b) of this section applies to each evidence sub-

mission made after the request for reconsideration is filed.

(2) Beneficiaries who are represented by providers or suppliers must comply with the requirements of paragraph (a) of this section.

**§ 405.968 Conduct of a reconsideration.**

(a) *General rules.* (1) A reconsideration consists of an independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim. In conducting a reconsideration, the QIC reviews the evidence and findings upon which the initial determination, including the redetermination, was based, and any additional evidence the parties submit or that the QIC obtains on its own. If the initial determination involves a finding on whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A) of the Act), a QIC's reconsideration must involve consideration by a panel of physicians or other appropriate health care professionals, and be based on clinical experience, the patient's medical records, and medical, technical, and scientific evidence of record to the extent applicable.

(b) *Authority of the QIC.* (1) National coverage determinations (NCDs), CMS Rulings, and applicable laws and regulations are binding on the QIC.

(2) QICs are not bound by LCDs, LMRPs, or CMS program guidance, such as program memoranda and manual instructions, but give substantial deference to these policies if they are applicable to a particular case. A QIC may decline to follow a policy, if the QIC determines, either at a party's request or at its own discretion, that the policy does not apply to the facts of the particular case.

(3) If a QIC declines to follow a policy in a particular case, the QIC's reconsideration explains the reasons why the policy was not followed.

(4) A QIC's decision to decline to follow a policy under this section applies only to the specific claim being reconsidered and does not have precedential effect.

(5) A QIC may raise and develop new issues that are relevant to the claims