

(i) For purposes of this section, the date of receipt of the contractor's notice of dismissal is presumed to be 5 days after the date of the notice of dismissal, unless there is evidence to the contrary.

(ii) For purposes of meeting the 60-day filing deadline, the request is considered as filed on the date it is received by the QIC indicated on the notice of dismissal.

(2) If the QIC determines that the contractor's dismissal was in error, it vacates the dismissal and remands the case to the contractor for a redetermination.

(3) A QIC's reconsideration of a contractor's dismissal of a redetermination request is final and not subject to any further review.

[70 FR 11472, Mar. 8, 2005, as amended at 70 FR 37703, June 30, 2005]

§ 405.976 Notice of a reconsideration.

(a) *Notification to parties*—(1) *General rules.* (i) Written notice of the reconsideration must be mailed or otherwise transmitted to all parties at their last known addresses, in accordance with the timeframes established in § 405.970(a) or (b).

(ii) The notice must be written in a manner reasonably calculated to be understood by a beneficiary.

(iii) The QIC must promptly notify the entity responsible for payment of claims under Part A or Part B of its reconsideration. If the reconsideration results in issuance of supplemental payment to a provider or supplier, the Medicare contractor must also issue an electronic or paper RA notice to the provider or supplier.

(2) *Overpayment cases involving multiple beneficiaries who have no liability.* 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 an ALJ level, or made part of the administrative record, 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 needed for an ALJ hearing is met when the reconsideration 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.

§ 405.978 Effect of a reconsideration.

A reconsideration is final and binding on all parties, unless—

(a) An ALJ 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.

REOPENINGS

§ 405.980 Reopenings of initial determinations, redeterminations, and reconsiderations, hearings and reviews.

(a) *General rules.* (1) A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the final 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 to revise the hearing decision; or

(iv) The MAC to revise the hearing or 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, hearing, or MAC 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 MAC may reopen as set forth in this section.

(5) The contractor's, QIC's, ALJ's, or MAC's decision on whether to reopen is final 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 and revise its 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