CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 688

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: SEPTEMBER 23, 2005

CHANGE REQUEST 3944

NOTE: ***Transmittal 678, dated September 16, 2005 is rescinded and replaced with Transmittal 688, dated September 23, 2005. Language was added to the effective and implementation dates. All other information remains the same.***

SUBJECT: Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Dates for All Requests for Redetermination Received by FIs on or After May 1, 2005, And All Requests for Redetermination Received by Carriers on or After January 1, 2006).

I. SUMMARY OF CHANGES: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). These changes manualize CMS 4064-IFC, published in the Federal Register on March 8, 2005. The instructions in this change request (CR) include redeterminations and reconsiderations. Other changes to the appeals process, including parties the appeals, appointment of representative, fraud and abuse, etc. will be manualized in another CR. Until the issuance of such CR, fiscal intermediaries are to follow the current manual sections or CR 3530.

NEW/REVISED MATERIAL

EFFECTIVE DATE: FI Redetermination requests received on or after May 1, 2005 and Carrier redetermination requests received on or after January 1, 2006

IMPLEMENTATION DATE: FI - December 16, 2005 and Carrier redetermination requests received on or after January 1, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	29/Table of Contents

N	29/310/Redetermination - The First Level of Appeal
N	29/310.4/The Redetermination
N	29/310.5/The Redetermination Decision
N	29/310.6/Dismissals
N	29/310.6.2/Vacating a Dismissal

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 688	Date: September 23, 2005	Change Request 3944

NOTE: ***Transmittal 678, dated September 16, 2005 is rescinded and replaced with Transmittal 688, dated September 23, 2005. Language was added to the effective and implementation dates. All other information remains the same.***

SUBJECT: Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Dates for All Requests for Redetermination Received by FIs on or After May 1, 2005, and All Requests for Redetermination Received by Carriers on or After January 1, 2006).

I. GENERAL INFORMATION

A. Background: The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. This new "reconsideration" is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

B. Policy: The purpose of this CR is to notify FIs and carriers about the upcoming transition to the new second level of the appeals process. For Part A and Part B redeterminations issued and mailed by FIs on or after May 1, 2005, the parties to the redetermination will have the right to appeal to a QIC. For Part B redeterminations issued and mailed by carriers on or after January 1, 2006, the parties to the redetermination will have the right to appeal to a QIC. All FI redeterminations issued and mailed before May 1, 2005, will have appeal rights to the Administrative Law Judge (ALJ) for Part A claims and to the hearing officer (HO) for Part B claims. All carrier redeterminations issued and mailed before January 1, 2006 will have appeal rights to the HO for Part B claims.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3944.1	The FI or carrier shall comply with, and is bound by, all applicable statutory and regulatory provisions, CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, change requests, national coverage determinations, carrier-issued local medical review policies, regional medical review policies, and local coverage determinations in conducting a redeterminations.	x		x	X					
3944.2	The FI or carrier shall change appeals language in all demand letters or other notices of revised initial determination in accordance with § 310.	x	x	x	x					
3944.3	The FI or carrier shall examine all issues in the claim when conducting a redetermination or all aspects of the claim related to the line item the appellant specifies in the request.	x	x	x	x					
3944.4	The FI or carrier shall complete and mail a redetermination notice for redeterminations within 60 days of receipt of the request with the exceptions noted in § 310.4.	x	x	x	x					
3944.5	The FI or carrier shall include any adjustment action as a result of a partial reversal or full reversal on the next scheduled release of the MSN/RA.	x	x	x	x					
3944.6	The FI or carrier shall obtain and review all available, relevant information needed to make a redetermination if one is requested.	x	x	x	x					
3944.7	The FI or carrier shall assign a different reviewer to complete a redetermination than the person who made the initial determination.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3944.8	The FI or carrier shall provide the appellant the opportunity to submit written evidence and arguments relating to the claim at issue.	x	x	x	x					
3944.9	The FI or carrier should review the claim to see if there is sufficient documentation and evidence to support that the item or services were actually furnished or were furnished as billed.	x	x	x	x					
3944.10	The FI or carrier shall take action to resolve the issue when it discovers that a claim or line item was previously paid in error in accordance with § 310.4 (C).	x	x	x	x					
3944.11	The FI or carrier shall not request documentation directly from a provider or supplier for a State-initiated appeal. If additional documentation is needed, the reviewer should request that the submitter of the appeal obtain and submit the necessary documentation.	x	x	x	x					
3944.12	The FI or carrier shall advise the provider or supplier to submit the required documentation for provider, physician, supplier, or beneficiary initiated appeals.	x	x	x	x					
3944.12.1	The FI or carrier shall notify the provider or supplier of the timeframe the provider or supplier has to submit the documentation.	x	x	x	x					
3944.12.2	The FI or carrier shall document the request for additional information in the redetermination case file.	x	x	x	x					
3944.12.3	If the additional documentation was not received within 14 calendar days from the date of the request, the FI or carrier shall conduct the redetermination based on the information in the file.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3944.12.4	The FI or carrier shall consider evidence that is received after the 14 day deadline, but before having made and issued the redetermination.	x	x	x	x					
3944.13	The FI or carrier shall notify the beneficiary, for beneficiary-initiated appeals, when the reviewer has asked the beneficiary's provider, physician, or supplier for additional documentation.	x	x	x	x					
3944.14	The FI or carrier shall routinely include instructions on the appropriate information to submit with appeal request in its provider newsletters and other educational literature.	x	x	x	x					
3944.15	If, as a result of a denial, a provider or supplier is required to make a refund to a beneficiary, the FI or carrier shall include the language found in § 310.5(B) in the redetermination.	x	x	x	x					
3944.16	If a party to the redetermination requests the contractor to vacate its dismissal and if the contractor determines there is good and sufficient cause, the FI or carrier shall reopen the dismissal and issue a new decision.	x	x	x	x					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3944.17	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv.			X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: FI redetermination requests received on or after May 1, 2005 and carrier redetermination requests received on or after January 1, 2006 **Implementation Date:** FI – December 16, 2005 and carrier redetermination requests received on or after January 1, 2006 **Pre-Implementation Contact(s):** Tara Boyd at 410-786-2069 or Jennifer Frantz at 410-785-9531 **Post-Implementation Contact(s):** Contact your local regional office	**Funding for implementation activities will be provided to contractors through the regular budget process.**

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

Table of Contents
(Rev. 688, 09-23-05)

310 - Redetermination - The First Level of Appeal

(Rev.688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

A party dissatisfied with an initial determination may request in writing that the contractor review its determination. A redetermination is the first level of appeal after the initial determination on Part A and Part B claims. It is a second look at the claim and supporting documentation and is made by a different employee. If an initial determination on a claim had not been made, there are not appeal rights on that claim (See §200 (C) for a list of actions that are not initial determinations and therefore do not have appeal rights). Previously, parties had the right to request a review or reconsideration over the telephone, however the regulations no longer provide this right. Contractors may choose to conduct telephone reopenings for clerical errors or omissions. (See §370.)

The reviewer must comply with, and is bound by, all applicable statutory and regulatory provisions. The reviewer may not overrule the provisions of the law or interpret them in a way different than CMS does; nor may the reviewer comment upon the legality, constitutional or otherwise, of any provision of the Act, regulations, or CMS policy in the review determination. The reviewer is also bound by all CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, change requests, national coverage determinations, carrier-issued local medical review policies (LMRP), regional medical review policies (RMRP), and local coverage determinations. The reviewer must consider the applicability of all CMS-issued policies and procedures (including LMRP and RMRP) to the facts of a given claim. The reviewer may not disregard or override an applicable LMRP or RMRP, nor may the reviewer change the amount required to be paid under the Physician Fee Schedule.

Previously, revised initial determinations had appeal rights to the hearing officer for part B claims where over $100 remained in controversy and appeal rights to the review level for part B claims where under $100 remained in controversy. For part A claims with revised initial determinations, appeal rights were provided at the reconsideration level. For all revised B of A initial determinations issued on or after May 1, 2005, the first level of appeal will be a redetermination. For all revised Part B initial determinations issued on or after January 1, 2006, the first level of appeal will be a redetermination. Contractors shall change appeals language in all demand letters or other notices of revised initial determinations (including Remittance Advice (RA) notices and Medicare Summary Notices (MSN) if used) in accordance with this section. Additional instructions regarding changes to the MSN and RA remarks will be forthcoming (e.g., revising the terminology for the levels of appeal and time frames to appeal).

310.4 - The Redetermination

(Rev.688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

The redetermination is an independent, critical examination of a Part A or B claim made by contractor personnel not involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, contractor personnel must examine all issues in the claim.

A. Timely Processing Requirements

The carrier must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of (D)(4) below). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties.

2. For partial reversals and full reversals, when all of the following actions have been completed:

a. the decision letter is mailed to the parties, and
b. the actions to initiate the adjustment action in the claims processing system are taken.

When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment.
3. For withdrawals and dismissals, the date dismissal notice is mailed to the parties.

B. Development of Appeal Case File

The reviewer must obtain and review all available, relevant information needed to make the determination. Other areas within the contractor may have information relevant to the claim(s) at issue. For example, the program integrity area (including medical review, overpayments, and fraud and abuse) may submit evidence to the reviewer for inclusion in the case file. Such evidence must be made available for inspection by an appellant upon request. Reviewers must exercise care in determining the weight to give fraud and abuse information where the source of the specified information is not provided. Although the name of the beneficiary or other source that provided the information that triggered an investigation is not always provided or necessary when reviewing the evidence, the case file must include information on the independent, subsequently developed investigation that supports denial of the claim(s). (See subsection D, below, for instructions on development of documentation.)

The development of the case file is important not only for the redetermination, but also to prepare for a potential appeal to the QIC. Proper development of the case file will assist the contractor in timely transmitting the case file to the QIC upon request. In cases of large overpayment cases involving many claims, this case file development is extremely important. When a reconsideration request is filed with the QIC, and the QIC requests a case file for a large overpayment case, it is critical the QIC obtain the case file timely so it can begin adjudication. Therefore, it should be a priority for the contractor to adequately develop case files.

C. Elements of the Redetermination

The following elements are essential to performing an adequate redetermination:

- *The reviewer must not be the same person who made the initial determination.*

- *How the contractor conducts its redetermination depends on the appellant's request and what is at issue. There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the correctness of the reasonable charge, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable.*

- *If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed.*

For appeals of a specific line item or service, the initial determination is the date of the first MSN or RA that states the decision. Adjustments to the claim that are included on later copies of the MSN or RA do not extend/change the appeal rights given under the initial determination. All other line items not yet reviewed may be reviewed within 120 days from the receipt of the initial determination, if requested.

- *Although the reviewer may not make a finding of criminal or civil fraud (see §280, "Fraud and Abuse"), the reviewer should review the claim to see if there is sufficient documentation and evidence supporting that the items or services were actually furnished or were furnished as billed.*

- *Appellants must have the opportunity to submit written evidence and arguments relating to the claim at issue. This does not mean the reviewer must request such material, but he/she must accept and consider any relevant documentation submitted.*

- *Correctness of Initial Determination is Questioned- While it is not the intent of the appeals process to audit favorable initial determinations, there may be times when the contractor questions the correctness of the initial payment decision. Since the contractor already notified the parties that part of the claim was covered, a subsequent denial could cause problems affecting the physician or other supplier and/or the beneficiary. When the contractor discovers that a claim or line items was previously paid in error, the contractor must take action to resolve the issue. If the contractor has reason to believe the initial determination should be reversed (i.e., ultimately making it more adverse to the party than the initial determination), it proceeds as follows:*

    - *It reviews the file carefully, with particular attention to the evidence that supported the original payment decision. It uses the payment policies that were in effect at the time the initial determination was made or the date of services as applicable.*

    - *If it believes that payment of a previous claim or line item(s) is not justified and this issue involved clinical judgment, it refers the case to a consultant for an opinion on whether the service(s)/item(s) was/were covered.*

    - *When the appeals staff confirms that a claim or line item(s) was/were paid in error, it should make a decision only on the originally noncovered services at issue in the redetermination. Next it should return the claim to overpayments to collect the overpayment and to issue a demand letter.*

D. Requests for Documentation

1. Requesting documentation for State-Initiated Appeals

The reviewer should not request documentation directly from a provider or supplier for a State-initiated appeal. If additional documentation is needed, the reviewer should request that the submitter of the appeal (i.e., the State or the party authorized to act on behalf of the Medicaid State Agency) obtain and submit necessary documentation.

2. Requesting documentation for Provider, Physician, Supplier, or Beneficiary-Initiated Appeals

For provider, physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the provider, physician, or other supplier of the timeframe the provider or supplier has to submit the documentation. The reviewer documents his/her request in the redetermination case file. The requested documents may be submitted via facsimile, at the reviewer's discretion. In rare cases, a provider or supplier might inform the reviewer that he/she is having trouble obtaining the supporting documentation, such as hospital records. In this situation the contractor may provide the provider, physician or other supplier with assistance in obtaining records. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the reviewer conducts the redetermination based on the

information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination. See 4 below for information on extension of the decision making timeframe for additional documentation that is submitted after the request.

3. Requesting documentation for Beneficiary-Initiated Appeals

For provider, physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. For beneficiary-initiated appeals, the reviewer notifies the beneficiary (either in writing or via a telephone call) when the reviewer has asked the beneficiary's provider, physician, or supplier for additional documentation. The beneficiary is advised (either in the letter or during a telephone call) that the provider, physician, or other supplier has 14 calendar days to submit the additional documentation that has been requested, and that if the documentation is not submitted, the reviewer will decide based on the evidence in the case file. If the reviewer sends the beneficiary a letter, it must include a description of the documentation that has been requested.

4. Extension for Receipt of Additional Documentation

When a party submits additional evidence after filing the request for redetermination, the contractor's 60-day decision-making timeframe is automatically extended for 14 calendar days for each submission. This additional 14 days is allowed for all documentation submitted by a party after the request, even when the documentation was requested by the contractor. Although this extension is granted to contractor for making decisions, it should not routinely be applied unless extra time is needed to consider the additional documentation.

5. General Information

The contractor routinely includes instructions on the appropriate information to submit with appeal requests in its provider newsletters and other educational literature. Providers, physicians and other suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.

310.5 - The Redetermination Decision

(Rev.688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

The law requires contractors to conclude and mail the redetermination within 60 days of receipt of the appellant's request, as indicated in §310.4. The contractor mails an unfavorable redetermination to the appellant and copies to each party or authorized representative of the each party (as applicable). The contractor mails a fully favorable redetermination to the appellant or authorized representative. For fully favorable, the

contractor also sends all parties the MSN or RA containing the adjustment action, if appropriate.

A. Favorable Determinations

If the determination is a full reversal (i.e., is fully favorable meaning when the Medicare approved amount minus any cost sharing provisions (insurance, deductibles, etc.) has been found payable), the contractor mails the appellant or appointed representatives a brief notification of the decision within 60 days of receipt of the request. It also sends an adjusted MSN or RA on the next scheduled release. The MSN provides the beneficiary with information as to his/her financial liability with regard to the claim(s) that are now payable.

If the determination is a partial reversal, the contractor sends all parties and appointed representative an adjusted MSN or RA and a redetermination letter including the rationale for the decision.

B. Determinations That Result in Refund Requirements

If, as the result of a denial, a provider or supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then the carrier must include the following language in the redetermination.

When the beneficiary is not liable, include the following language:

Therefore, you (the beneficiary) are not responsible for the changes billed by (provider's name) except for any charges for services never covered by Medicare. If you (the beneficiary) have paid (provider's name) for these service, you may be entitled to a refund. To get this refund, please contact this office and send the following items:

- *A copy of this notice,*
- *The bill you received for the services, and*
- *The payment receipt, your cancelled check, or any other evidence showing that you have already paid (provider's name for the services at issue.*

You should file your written request for payment within 6 months of the date of this notice.

If, as the result of a denial, a provider or supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then the carrier must send a copy of the adjusted RA in the following situations:

1. *A nonparticipating physician not accepting assignment who, based on the redetermination, now has a refund obligation under §1842(l)(1) of the Act;*

2. A nonparticipating supplier not accepting assignment who is determined to have a refund obligation pursuant to §1834(a)(18), due to a denial under either §1834(a)(17)(B) or §1834(j)(4) of the Act; or,

3. A denial based on §1879(h) of the Act of an assigned claim submitted by a supplier, where it is determined under §1834(a)(18) of the Act that the supplier must refund any payments (including deductibles and coinsurance) collected from the beneficiary.

310.6 - Dismissals

(Rev.688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

The contractor may dismiss a request for a redetermination under the following circumstances:

1. Request of Party

A request for redetermination may be withdrawn at any time prior to the mailing of the redetermination upon the request of the party or parties filing the request for redetermination. The request to withdraw is one of the reasons for which a case can be dismissed. A party may request a dismissal by filing a written notice of such request with the contractor or over the telephone. This dismissal of a request for redetermination is binding unless vacated by the contractor.

2. Dismissal for Cause

The contractor may dismiss a redetermination request, either entirely or as to any stated issue, under either of the following circumstances:

- *Where the party requesting a redetermination is not a proper party or does not otherwise have a right to a redetermination.*

3. Failure to File Timely

When a request for redetermination is not filed within the time limit required and the contractor did not find good cause for failure to file timely, it should dismiss the request.

4. Appointment of Representative is Incomplete or Absent

When an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment form and the appointment is not corrected within the time limit discussed above in §60.5.8.A.2 or when the individual fails to include an appointment with the appeal request, the contractor should dismiss the request.

***NOTE:** If the appellant resubmits appeal request with an appointment of representative form, the contractor does not count duplicate redetermination requests. (See Chapter 6 of the Medicare Financial Management Manual, CMS Pub 100-6.)*

5. Party Failed to Make A Valid Request

When the contractor determines the provider, supplier, or State failed to make out a valid request for redetermination that substantially complies with § 310 (B) (1) or (2).

6. Beneficiary Dies While Request is Pending

When a beneficiary or the beneficiary's representative files a request for redetermination, but the beneficiary dies while the request is pending, and all of the following criteria apply:

(a) The beneficiary's surviving spouse or estate has no remaining financial interest in the case. In deciding this issue, the contractor considers if the surviving spouse or estate remains liable for the services for which payment was denied or a Medicare contractor held the beneficiary liable for subsequent similar services under the limitation of liability provisions based on the denial of payment for services at issue;

(b) No other individual or entity with a financial interest in the case wishes to pursue the appeal; and

(c) No other party filed a valid and timely redetermination request.

310.6.2 - Vacating a Dismissal

(Rev.688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

A party to the redetermination may also request the contractor to vacate its dismissal within 6 months of the date of the mailing of the dismissal notice if good and sufficient cause is established. The contractor determines if there is good and sufficient cause and if there is, the contractor reopens the dismissal and issues a new decision.