

<b>CMS Manual System</b>	Department of Health & Human Services (DHHS)
<b>Pub 100-08 Medicare Program Integrity</b>	Centers for Medicare & Medicaid Services (CMS)
Transmittal 221	Date: SEPTEMBER 6, 2007
	Change Request 5467

**THIS CORRECTS TRANSMITTAL 212, CHANGE REQUEST 5467, DATED JUNE 29, 2007. THE ONLY CHANGE IS THE STREET ADDRESS OF WHERE TO SEND THE ADMINISTRATIVE LAW JUDGE REQUESTS, ALL OTHER INFORMATION REMAINS THE SAME.**

**SUBJECT:** Administrative Appeals for Provider Enrollment

**I. UMMARY OF CHANGES:** The administrative appeals section of the PIM is being revised to include instructions regarding corrective action plans (CAPs) and the scope of review.

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE:** October 1, 2007

**IMPLEMENTATION DATE:** October 1, 2007

*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: (N/A if manual is not updated)**

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/19/Administrative Appeals

**III. FUNDING:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

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

# Attachment - Business Requirements

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## I. GENERAL INFORMATION

**A. Background:** Section 936 of the Medicare Modernization Act (MMA) establishes an appeals process for providers and suppliers whose Medicare enrollment application has been denied or Medicare billing privileges revoked.

**B. Policy:** The Program Integrity Manual (PIM), chapter 10, section 19, incorporates the new appeals provisions of Section 936 of the MMA and has been revised to include instructions regarding corrective action plans (CAPs) and the scope of review.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A /	D M	F I	C A	D M	R H	Shared- System Maintainers			OTHER
		B E	E R	R E	R R	I C	H I	F I S S	M C S	V M S	
5467.1	Contractors shall provide for submittal of CAPs for denied or revoked billing numbers.	X	X	X	X		X				NSC
5467.2	Contractors shall limit the scope of their review to the reason for denial or revocation.	X			X						RO NSC

## III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A /	D M	F I	C A	D M	R H	Shared- System Maintainers			OTHER
		B E	E R	R E	R R	I C	H I	F I S S	M C S	V M S	

									F I S S	M C S	V M S	C W F	
	None.												

#### IV. SUPPORTING INFORMATION

**A. For any recommendations and supporting information associated with listed requirements, use the box below:**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**B. For all other recommendations and supporting information, use the space below:**

#### V. CONTACTS

**Pre-Implementation Contact(s):** Alisha Banks, 410-786-0671, Alisha.Banks@cms.hhs.gov

**Post-Implementation Contact(s):** Alisha Banks, 410-786-0671, Alisha.Banks@cms.hhs.gov

#### VI. FUNDING

**A. For TITLE XVIII Contractors, use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

**B. For Medicare Administrative Contractors (MAC), use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## **19 - Administrative Appeals**

**(Rev. 221; Issued: 09-06-07; Effective/Implementation Dates: 10-01-07)**

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that initial determination. This appeal process applies to all provider and supplier types, not just those defined in 42 CFR §498, and ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (“MMA”), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a contractor hearing decision to an Administrative Law Judge (“ALJ”) of the Department of Health and Human Services (“DHHS”). Providers and suppliers then can seek review by the Departmental Appeals Board (“DAB”) and then may request judicial review.

### **Denial of an Enrollment Application/Revocation of Medicare Billing Privileges**

#### **A. Carriers (including NSC *and A/B MACs*)**

If a Medicare contractor reviews an initial enrollment application for a provider or supplier and finds a basis for denying the application pursuant to 42 CFR §424.*530*, such as; the provider or supplier does not meet one or more of the Federal or State requirements, then the Medicare contractor will deny the application and send a denial letter explaining the reason for the denial to the provider or supplier. The letter will provide appeal rights and include the procedures for requesting Medicare contractor reconsideration. Contractor reconsiderations can be conducted by a Hearing Officer (HO) or senior staff having expertise in provider enrollment and independent from the initial decision to deny or revoke enrollment. *Note - NSC reconsiderations are only conducted by a hearing officer.*

Similarly, when a Medicare contractor discovers that there is a basis for revoking a provider or supplier’s billing number, such as; a provider or supplier that no longer meets one of the requirements for a billing number, then the provider or supplier’s billing number is revoked. The contractor sends the provider or supplier a letter that explains the reason for revoking their billing number, the effective date of the revocation (30 days from the date the notice is mailed, *or 15 days from the date the notice is mailed for DMEPOS suppliers*), appeal rights and procedures for requesting Medicare contractor reconsideration.

*The contractor, including the NSC, shall accept the submission of a corrective action plan (CAP) for denied or revoked billing numbers. Submission of a CAP shall contain, at a minimum, verifiable evidence of provider or supplier compliance at the time the revocation or denial was issued. If a CAP for a denied application is approved by a contractor, billing privileges can be re-issued and retroactive to the date of the denial or revocation. If a CAP is approved which restores billing privileges, the Division of*

*Provider and Supplier Enrollment's (DPSE's) approval is required for reinstatement of the revoked billing number.*

*The contractor shall process a CAP within 60 days. During this process, the contractor shall not toll the filing requirements associated with an appeal. However, the contractor can make a good cause determination for any appeal that is submitted beyond the timely filing period.*

### **Request for Reconsideration (formerly Contractor Hearing)**

A provider or supplier that wishes to request a reconsideration must file its request, in writing, with the Medicare contractor within 60 days after the postmark of the notice to be considered timely filed. *A DMEPOS supplier must file its request within 90 days after the postmark of the notice to be considered timely filed.* The date the request is received by the contractor is treated as the date of filing. The request must be signed by the physician, non-physician practitioner, or any responsible authorized official within the entity. For DMEPOS suppliers, the request must be signed by the authorized representative, *delegated official*, owner or partner. *Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.*

Upon receipt of the reconsideration, the Medicare contractor *shall* send an acknowledgment letter to the provider or supplier to acknowledge receipt of their request. In its acknowledgment letter, the contractor shall advise the requesting party that the reconsideration will be conducted and a determination issued as soon as possible, but no later than 90 days from the date of the request. The contractor shall include a copy of its acknowledgment letter in the reconsideration file. A model acknowledgment letter can be found in §19.1. The language therein may need to be modified, depending upon: (1) whether it is the contractor or HO assigned to the case that is sending out the acknowledgment, and (2) any special circumstances involved in the case.

If a timely request for a reconsideration is made, a HO, not involved in the original *adverse* determination, must hold an on-the-record reconsideration and issue a determination within 90 days of receipt of the appeal request. The provider, supplier or the contractor may offer new evidence. *It is the responsibility of the* provider or supplier to show that its enrollment application was incorrectly disallowed or billing privileges revoked erroneously.

*In reviewing an initial enrollment decision or a revocation, a Medicare contractor, including the NSC, should limit the scope of its review to the contractor's reason for imposing a denial or revocation at the time it issued the action and whether the contractor made the correct decision (i.e., denial/revocation). If a provider or supplier provides evidence that demonstrates or proves that they met or maintained compliance after the date of denial or revocation, the contractor shall exclude this information from the scope of the review.*

If a request for reconsideration is filed late, the HO makes a finding of good cause before taking any other action on the appeal. These time limits may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows, or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or
- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

The HO issues a written decision as soon as practicable, but no later than 90 days from the date of the request and forwards the decision to the Medicare contractor and by certified mail to the provider, supplier or his authorized representative. The decision includes (i) information about the provider, supplier, or contractor's further right to appeal; (ii) the address to which the written appeal must be mailed; (iii) the date by which the appeal must be filed; and (iv) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision.) A model decision letter can be found in §19.1.

A request for reconsideration may be withdrawn at any time prior to the mailing of the reconsideration decision either by the party that filed the appeal request or their authorized representative. The request for withdrawal must be in writing, signed, and filed with the Medicare contractor.

When the Medicare contractor receives a withdrawal request, it sends a letter to the provider or supplier acknowledging its receipt and advising that reconsideration action will be terminated.

Contractors shall maintain a report detailing the number of reconsideration requests they receive and their outcome (e.g., decision withheld, reversed, or further appeal requested). Contractors are not required to submit this information to CMS but it must be provided upon request.

### **Request for Administrative Law Judge (ALJ) Hearing**

If the provider or supplier is not in agreement with the reconsidered determination a further appeal can be filed with an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. Prior to filing an appeal with the ALJ, the contractor should notify and consult with their DPSE contractor liaison. ALJ requests should be sent to:

Department of Health and Human Services  
Departmental Appeals Board (DAB)  
Civil Remedies Division, Mail Stop 6132  
*330* Independence Avenue, S.W.  
Cohen Bldg, Room G-644  
Washington, D.C. 20201  
ATTN: CMS Enrollment Appeal

*Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.*

Upon receipt of the request to file an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider or supplier, CMS, and the *regional Office of General Counsel (OGC) detailing a scheduled pre-hearing conference*. The *OGC will assign an attorney that will represent CMS during the pre-hearing conference and also serve* as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing conference to discuss any issues. *The Medicare contractors shall work with and provide the OGC attorney with all necessary documentation. Any settlement proposals, as a result of the pre-hearing conference, will be brought back and* addressed with CMS.

#### **Request for Departmental Appeals Board (DAB) Hearing**

If there are still outstanding issues once the ALJ rules on the case, a provider or supplier may request a DAB review. A provider, supplier or Medicare contractor that wishes to request a review by the DAB must file its request within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing. The DAB may admit additional evidence into the record if the Board considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. Additional information may be presented orally to the Board, which will be prepared by transcript and made available to any party upon request.

#### **Request for Judicial Review**

Any provider or supplier dissatisfied with a DAB decision has a right to seek judicial review by timely filing a civil action in a United States District Court. The time limit for filing is 60 days from receipt of the notice of the DAB's decision.

### **B. Fiscal Intermediary**

If a Medicare contractor reviews an initial enrollment application for a provider or certified suppliers and finds that the application could be denied pursuant to 42 CFR §424.530, such as; a facility's failure to meet one or more of the federal or state requirements, then the Medicare contractor sends a recommendation for denial to the CMS Regional Office (RO). If the RO finds that the contractor's recommendation is consistent with the applicable rules and regulations, a denial letter is sent to the provider or certified supplier explaining the reason for the denial. The letter will provide appeal rights and include the procedures for requesting RO reconsideration.

Similarly, when a Medicare contractor or the State Survey and Certification agency discover that a provider or certified supplier no longer meets one of the requirements for a billing number they contact the RO and recommend revocation of their billing privilege. If the RO finds that the contractor's recommendation is consistent with the applicable rules and regulations, a letter is sent to the provider or certified supplier explaining the reason for the revocation of billing privileges, the effective date of the revocation (15 days from the date the notice is mailed), appeal rights and procedures for requesting a RO reconsideration.

*The RO shall accept the submission of a corrective action plan (CAP) for denied or revoked billing numbers. Submission of a CAP shall contain, at a minimum, verifiable evidence of the provider or certified supplier's compliance at the time the revocation or denial was issued. If a CAP for a denied application is approved by a contractor, billing privileges can be re-issued and retroactive to the date of the denial or revocation. If a CAP is approved which restores billing privileges, the Division of Provider and Supplier Enrollment's (DPSE) approval is required for reinstatement of the revoked billing number.*

*The RO shall process a CAP within 60 days. During this process, the RO shall not toll the filing requirements associated with an appeal. However, the RO can make a good cause determination for any appeal that is submitted beyond the timely filing period.*

### **Request for RO Reconsideration**

A provider or certified supplier that wishes to request a reconsideration must file its request, in writing, with the RO within 60 days after the postmark of the notice to be considered timely filed. The date the request is received by the RO is treated as the date of filing. The request may be signed by the authorized official within the entity. *Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.*

Upon receipt of the reconsideration, the RO *shall* send an acknowledgment letter to the provider or certified supplier to acknowledge receipt of their request. In its acknowledgment letter, the RO shall advise the requesting party that the reconsideration will be conducted and a determination issued as soon as possible, but no later than 90

days from the date of the request. The RO shall include a copy of its acknowledgment letter in the reconsideration file. A model acknowledgment letter can be found in §19.1.

If a timely request for a reconsideration is made, a RO personnel, not involved in the original determination to deny enrollment, must hold an on-the-record reconsideration and issue a determination within 90 days of receipt of the appeal request. The provider, certified supplier or the contractor may offer new evidence. *It is the responsibility of* the provider or certified supplier to show that its enrollment application was incorrectly disallowed or billing privileges revoked erroneously.

*In reviewing an initial enrollment decision or a revocation, a RO should limit the scope of its review to the contractor's reason for imposing a denial or revocation at the time that it issued the action and whether the RO made the correct decision (i.e., denial/revocation). If a provider or supplier provides evidence that demonstrates or proves that they met or maintained compliance, after the date of denial or revocation, the RO shall exclude this information from the scope of the review.*

If a reconsideration request is filed late, the RO makes a finding of good cause before taking any other action on the appeal. These time limits may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows, or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or
- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

The RO issues a written decision as soon as practicable, but no later than 90 days from the date of the request and forwards the decision by certified mail to the Medicare contractor, the provider, certified supplier or his authorized representative. The decision includes (i) information about the provider, supplier, or contractor's further right to appeal; (ii) the address to which the written appeal must be mailed; (iii) the date by which the appeal must be filed; and (iv) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision.) A model decision letter can be found in §19.1.

A request for reconsideration may be withdrawn at any time prior to the mailing of the reconsideration decision either by the party that filed the appeal request or their authorized representative. The request for withdrawal must be in writing, signed, and filed with the RO.

When the RO receives a withdrawal request, it sends a letter to the provider or certified supplier acknowledging its receipt and advising that reconsideration action will be terminated.

The RO shall maintain a report detailing the number of reconsideration requests they receive and their outcome (e.g., decision withheld, reversed, or further appeal requested). The RO are not required to submit this information to CMS but it must be provided upon request.

### **Request for ALJ Hearing**

If the provider or certified supplier is not in agreement with the reconsidered determination a further appeal can be filed with an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such appeal must be filed, in writing, within 60 days from the receipt of the reconsideration decision. Prior to filing an appeal with the ALJ, the contractor should notify and consult with their DPSE contractor liaison. ALJ requests should be sent to:

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within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing. The DAB may admit additional evidence into the record if the Board considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. Additional information may be presented orally to the Board which will be prepared by transcript and made available to any party upon request.

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