CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 440	**Date: November 23, 2012**
	Change Request 8110

SUBJECT: Revision to Appeals Section of Chapter 15 of the Program Integrity Manual (PIM)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update Pub. 100-08, Chapter 15, section 25 of this manual.

EFFECTIVE DATE: December 24, 2012
IMPLEMENTATION DATE: December 24, 2012

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.25/Appeals Process
N	15/15.25.1/Appeals Involving Non-Certified Suppliers
N	15/15.25.1.1/Corrective Action Plans (CAPs)
N	15/25.1.2/Reconsideration Requests
N	15/25.1.3/Additional Appeal Levels
N	15/15.25.2/Appeals Involving Certified Providers and Certified Suppliers
N	15/15.25.2.1/Corrective Action Plans (CAPs)
N	15/15.25.2.2/Reconsideration Requests
N	15/15.25.2.3/Additional Appeal Levels

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out with their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 440	Date: November 23, 2012	Change Request: 8110

SUBJECT: Revision to Appeals Section of Chapter 15 of the Program Integrity Manual (PIM)

EFFECTIVE DATE: December 24, 2012

IMPLEMENTATION DATE: December 24, 2012

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to update Pub. 100-08, Chapter 15, section 25 of this manual.

B. Policy: This CR updates Pub. 100-08, Chapter 15, section 25 of this manual. Most of the changes in this CR are editorial in nature. Any policy changes will be reflected in the CR's business requirements.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8110.1	If a revoked non-certified supplier submits a corrective action plan (CAP) based on 42 CFR 424.535(a)(2), (a)(3) or (a)(5), the contractor shall notify the supplier via letter or e-mail that the CAP cannot be considered.		X			X						
8110.2	For cases before the Administrative Law Judge, the contractor shall compile and send all relevant case materials to the applicable Office of General Counsel (OGC) attorney upon the latter's request within 5 calendar days of said request.	X	X		X	X	X					
8110.3	If the contractor inadvertently receives a CAP or reconsideration request from a certified provider or certified supplier, the contractor shall immediately forward it to the address listed in Chapter 15, section 15.25.2.1(A) of this manual, if possible, to the following mailbox: providerenrollmentappeals@cms.hhs.gov.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out with their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.440, Issued: 11-23-12)

15.25 – Appeals Process

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Background

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privileges *are* revoked *may* request an appeal of that determination. *Change of information request denials, reassignment denials, and effective date determinations for initial enrollments may also be appealed.*

This appeal process applies to all providers and suppliers - not *merely* 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 reconsideration decision to an administrative law judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers *may thereafter* seek review by the Departmental Appeals Board (DAB) and *may then* request judicial review.

B. Notification Letters for Denials and Revocations

If a Medicare *contractor finds* a *legal* basis for denying an application - *and, if applicable under section 15.8.4 of this chapter, receives approval from the Provider Enrollment Operations Group (PEOG) for said denial* - th*e c*ontractor shall deny the application and notify the provider or supplier by letter. The denial letter shall contain:

- A legal (i.e., regulatory) basis for each reason for the denial;
- A clear explanation of why the application is being denied, including the facts or evidence *that the contractor used in making its* determination;
- An explanation of why the provider or supplier does not meet *the applicable enrollment criteria;*
- Procedures for submitting a corrective action plan (CAP); and
- Complete and accurate information about the provider or supplier's further appeal rights.

Similarly, when a Medicare contractor discovers a basis for revoking a provider or supplier's billing privileges - *and, if applicable under section 15.27.2 of this chapter, receives approval from PEOG for the revocation* - the contractor shall revoke billing privileges and notify the provider or supplier by letter. The revocation letter shall contain:

- A legal (i.e., regulatory) basis for each reason for revocation;
- A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence *that the contractor used in making its* determination;
- An explanation of why the provider or supplier does not meet *the applicable enrollment criteria;*
- The effective date of the revocation *(see section 15.27.2(C) of this chapter for more information)*;
- Procedures for submitting a CAP; and
- Complete and accurate information about the provider or supplier's further appeal rights.

15.25.1 - Appeals Involving Non-Certified Suppliers
(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

Sections 15.25.1.1 through 15.25.1.3 below apply to:

- *Individuals and solely-owned entities completing the Form CMS-855I*
- *Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)*
- *Suppliers completing the Form CMS-855B, with the exception of ambulatory surgical centers and portable x-ray suppliers*

15.25.1.1 – Corrective Action Plans (CAPs)
16 (Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Requirements and Submission of CAPs

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;

(4) For a revocation, be based on a revocation reason other than § 424.535(a)(2), (a)(3), or (a)(5). Per § 424.535(a)(1), CAPs for revocations based on § 424.535(a)(2), (a)(3), or (a)(5) shall not be accepted. If the supplier submits such a CAP, the contractor shall notify the supplier via letter or e-mail that it cannot be considered.

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above, the contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

***Note:** The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP.*

B. Processing and Approval of CAPs

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare

requirements or the receipt date of the application – subject, of course, to any applicable "backbilling" restrictions. (See section 15.17 of this chapter for more information.) For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

C. Concurrent Submission of CAP and Reconsideration Request

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- *It cannot be appealed.*
- *The contractor shall notify the supplier of the denial via letter.*
- *The supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.*
- *The reconsideration request, if submitted, shall be processed.*

15.25.1.2– Reconsideration Requests

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Timeframe for Submission

A supplier that wishes to request a reconsideration must file its request in writing with the Medicare contractor within 60 days after the postmark date of the denial or revocation notice to be considered timely filed. The contractor shall extend the filing period an additional 5 days to allow for mail time. A reconsideration request submitted on the 65th day that falls on a weekend or holiday shall still be considered timely filed. The date on which the contractor receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, the reconsideration HO shall make a finding of good cause before taking any other action on the appeal. The time limit 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.*

B. Signatures

The reconsideration request must be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.
*(**Note:** The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.)*

For DMEPOS suppliers, the request must be signed by the authorized official, delegated official, owner or partner.

C. Contractor's Receipt of Reconsideration Request

Upon receipt of a reconsideration request, the HO shall send a letter to the supplier to acknowledge receipt of its request. In his or her acknowledgment letter, the HO shall advise the requesting party that the reconsideration will be conducted and a determination issued within 90 days from the date of the request. The HO shall include a copy of the acknowledgment letter in the reconsideration file.

D. Reconsideration Determination

If a timely request for a reconsideration is made, the reconsideration shall be conducted by a HO or senior staff having expertise in provider enrollment and who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination. The HO must hold an on-the-record reconsideration and issue a determination within 90 days of the date of the appeal request. The supplier or the Medicare contractor may offer new evidence. It is the responsibility of the supplier to show that its enrollment application was incorrectly denied or its billing privileges were revoked erroneously.

In reviewing the original enrollment decision, the HO should limit the scope of its review to (1) the Medicare contractor's reason(s) for the denial or revocation at the time of the contractor's decision, and (2) whether the contractor made the correct decision. (The contractor cannot introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.) If a supplier provides evidence that demonstrates or proves that it met or maintained compliance after the date of denial or revocation, the HO shall exclude this information from the scope of its review.

E. Issuance of Reconsideration Decision

The HO shall issue a written decision within 90 days of the date of the request. He/she shall: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the supplier. The reconsideration letter shall include:

- *The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;*
- *A summary of the documentation that the supplier provided;*
- *A clear explanation of why the HO is upholding or overturning the denial or revocation action in sufficient detail for the supplier to understand the HO's decision and, if applicable, the nature of the supplier's deficiencies;*
- *If applicable, the regulatory basis to support each reason for the denial or revocation;*
- *If applicable, an explanation of how the supplier does not meet the enrollment criteria or requirements;*

- *Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the addresses to which the written appeal must be mailed or e-mailed; and*

- *Information the supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).*

If the HO overturns the contractor's decision, the contractor shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable "backbilling" restrictions. (See section 15.17 of this chapter for more information.) The contractor shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System. For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse.

F. Withdrawal of Reconsideration Request

The supplier or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with the Medicare contractor. If the contractor receives such a request, it shall send a letter or e-mail to the supplier acknowledging the receipt of the request and advising that the reconsideration action will be terminated.

G. Reports

The contractor shall maintain a report detailing the number of reconsideration requests it receives, the outcomes (e.g., decision withheld, reversed, or further appeal requested or requests withdrawn), and the reason(s) for whatever decision was made. The contractor is not required to submit this information to CMS but it must be provided upon request.

15.25.1.3 – Additional Appeal Levels

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Administrative Law Judge (ALJ) Hearing

CMS, a Medicare contractor, or a supplier dissatisfied with a reconsidered determination is entitled to a hearing before 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 an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. 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

(ALJ requests can also be submitted electronically at https://dab.efile.hhs.gov/.)

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

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the supplier, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will 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 to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS.

B. Departmental Appeals Board (DAB) Hearing

CMS, a Medicare contractor, or a supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be 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 to make its determination. The DAB may admit additional evidence into the record if the DAB 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. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

C. Judicial Review

A supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed within 60 days from receipt of the notice of the DAB's decision.

15.25.2 - Appeals Involving Certified Providers and Certified Suppliers

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

Sections 15.25.2.1 through 15.25.2.3 below apply to:

- *Providers and suppliers completing the Form CMS-855A*
- *Ambulatory surgical centers*
- *Portable x-ray suppliers*

15.25.2.1 – Corrective Action Plans (CAPs)

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Submission of CAPs

The CAP process gives a provider or supplier (hereinafter collectively referred to as "providers") an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(4) For a revocation, be based on a revocation reason other than § 424.535(a)(2), (a)(3), or (a)(5). Per § 424.535(a)(1), CAPs for revocations based on § 424.535(a)(2), (a)(3), or (a)(5) cannot be accepted. The Provider Enrollment Operations Group (PEOG), which processes all CAPs, will notify the provider that the CAP cannot be accepted.

CAP requests must be sent to the following address:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group
7500 Security Boulevard
Mailstop AR 18-18-50
Baltimore, MD 21244-1850

If the contractor inadvertently receives a CAP request, it shall immediately forward it to PEOG at this address or, if possible, to the following PEOG mailbox: providerenrollmentappeals@cms.hhs.gov.

***Note: F**urther that:*

- *PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.*

- *The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.*

B. Processing and Approval of CAPs

PEOG will process a CAP within 60 days. During this period, PEOG will not toll the filing requirements associated with a reconsideration request.

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and issue or restore billing privileges (as applicable), and (2) notify the provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

If PEOG denies a CAP, it will notify the provider via letter, on which the contractor will be copied.

15.25.2.2– Reconsideration Requests

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Timeframe for Submission

A provider that wishes to request a reconsideration must submit its request, in writing, to the Provider Enrollment Operations Group (PEOG) within 60 days after the postmark date of the denial or revocation notice to be considered timely filed. The mailing address is:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group

7500 Security Boulevard
Mailstop AR 18-18-50
Baltimore, MD 21244-1850

PEOG will extend the filing period an additional 5 days to allow for mail time. A reconsideration request submitted on the 65th day that falls on a weekend or holiday will still be considered timely filed. The date on which PEOG receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, PEOG will make a finding of good cause before taking any other action on the appeal. The time limit 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.*

B. Signatures

A reconsideration request must be signed by an authorized official, delegated official, or legal representative of the provider. The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

C. Receipt of Reconsideration Request

Upon receipt of a reconsideration request, PEOG will send a letter to the provider to acknowledge receipt of the request. In its acknowledgment letter, PEOG will advise the provider that the reconsideration will be conducted and a determination issued within 90 days from the date of the request. PEOG will include a copy of the acknowledgment letter in the reconsideration file.

If the contractor inadvertently receives a reconsideration request from a certified provider or certified supplier, it shall immediately forward it to PEOG at this address or, if possible, to the following PEOG mailbox: providerenrollmentappeals@cms.hhs.gov.

D. Reconsideration Determination

As already stated, if a timely request for a reconsideration is made, PEOG will consider the request and issue a determination within 90 days of the request. The provider or the Medicare contractor may offer new evidence. It is the provider's responsibility to show that its enrollment application was incorrectly denied or that its billing privileges were revoked erroneously.

In reviewing the original enrollment decision, PEOG will limit the scope of its review to (1) the Medicare contractor's reason(s) for the denial or revocation at the time of the contractor's decision, and (2) whether the contractor made the correct decision. (The contractor cannot introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.) If a provider furnishes evidence that demonstrates or proves that it met or maintained compliance after the date of denial or revocation, PEOG will exclude this information from the scope of its review.

E. Issuance of Reconsideration Decision

PEOG will issue a written decision within 90 days of the date of the request. It will: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the provider or the individual who signed the reconsideration request. The reconsideration letter will include:

- *The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;*

- *A summary of the documentation that the provider furnished;*

- *A clear explanation of why PEOG is upholding or overturning the denial or revocation action in sufficient detail for the provider to understand PEOG's decision and, if applicable, the nature of the provider's deficiencies;*

- *If applicable, the regulatory basis to support each reason for the denial or revocation;*

- *If applicable, an explanation of how the provider does not meet the enrollment criteria or requirements;*

- *Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the address to which the written appeal must be mailed or e-mailed; and*

- *Information that the provider must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).*

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and issue or restore billing privileges (as applicable), and (2) notify the provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

F. Withdrawal of Reconsideration Request

The provider or the individual who signed the reconsideration request may withdraw its request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with PEOG at the address in (A) above.

15.25.2.3 – Additional Appeal Levels

(Rev.440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)

A. Administrative Law Judge (ALJ) Hearing

CMS, a Medicare contractor, or a provider dissatisfied with a reconsidered determination is entitled to a hearing before 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 an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. 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

(ALJ requests can also be submitted electronically at https://dab.efile.hhs.gov/.)

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

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will 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 to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS.

B. Departmental Appeals Board (DAB) Hearing

CMS, a Medicare contractor, or a provider dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be 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 to make its determination. The DAB may admit additional evidence into the record if the DAB 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. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

C. Judicial Review

A provider dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed within 60 days from receipt of the notice of the DAB's decision.