

CMS Manual System	Department of Health & Human Services
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services
Transmittal 275	Date: DECEMBER 12, 2008
	Change Request 6248

SUBJECT: Administrative Appeals for Provider Enrollment

I. SUMMARY OF CHANGES: This revision implements a number of provisions that are applicable to all providers and suppliers, including durable medical equipment, orthotics, prosthetics and supplies whose Medicare enrollment application has been denied or whose Medicare billing privileges have been revoked.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 12, 2009

IMPLEMENTATION DATE: January 12, 2009

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:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within 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 does 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.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 275	Date: December 12, 2008	Change Request: 6248
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SUBJECT: Administrative Appeals for Provider Enrollment

Effective Date: January 12, 2009

Implementation Date: January 12, 2009

I. GENERAL INFORMATION

A. Background: This revision implements a number of provisions that are applicable to all providers and suppliers, including durable medical equipment, orthotics, prosthetics and supplies whose Medicare enrollment application has been denied or whose Medicare billing privileges have been revoked.

B. Policy: The Program Integrity Manual (PIM) is being updated to incorporate changes made to the Appeals Regulation (CMS-6003).

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6248.1	Contractors shall deny a provider or certified supplier's application without submitting a recommendation for denial to the State/regional office if a denial reason listed in the PIM, chapter 10, section 6.2, is implicated.	X		X							
6248.2	Contractors shall include in their denial/revocation letters (or recommended denial/revocation letters) sufficient detail to allow the provider/supplier to understand the nature of its deficiencies.	X		X	X						RO NSC
6248.3	Contractors shall include in their denial/revocation letters the address to which written appeals must be mailed.	X		X	X						RO NSC
6248.4	Contractors/hearing officers shall include in their reconsideration letters a summary of the documentation submitted by the provider/supplier.	X			X						RO NSC
6248.5	The CMS/contractors dissatisfied with a reconsidered determination may request a hearing before an administrative law judge (ALJ).	X		X	X	X					DPSE
6248.6	The CMS/contractor dissatisfied with an ALJ hearing decision may request board review.	X		X	X	X					DPSE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	None.										

IV. SUPPORTING INFORMATION

Section 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:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHs)* use only one of the following statements:

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

Section B: For *Medicare Administrative Contractors (MACs)*, use the following statement:

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 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.

19 - Administrative Appeals

(Rev. 275; Issued 12-12-08; Effective/Implementation Date: 01-12-09)

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that determination. This appeal process applies to all providers and suppliers, 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 reconsideration 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/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, the *Medicare* contractor shall deny the application and *notify the* provider or supplier *by letter*. The denial letter shall contain:

- *the reason for the denial in sufficient detail to allow the provider or supplier to understand the nature of its deficiencies;*
 - the regulatory basis to support each reason or reasons for the denial;
 - procedures for submitting a corrective action plan (CAP); and
 - *the provider or supplier's* appeal rights, procedures for requesting a *Medicare* contractor reconsideration *and the address to which the written appeal must be mailed.*

Similarly, when a *Medicare* contractor discovers that there is a basis for revoking a provider or supplier's billing privileges, such as; *the* provider or supplier no longer meets one of the requirements for billing privileges, the *contractor shall revoke* billing privileges *and notify the provider or supplier by letter*. The revocation letter *shall* contain:

- *the reason for the revocation in sufficient detail for the provider or supplier to understand the nature of its deficiencies;*
 - the regulatory basis to support each reason or reasons for the revocation;
 - the effective date of the revocation (30 days from the date the notice is mailed *for providers or suppliers*, or 15 days from the date the notice is mailed for DMEPOS suppliers. *A revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment. The effective date of a license suspension/revocation is effective with the date of the suspension/revocation);*

- *procedures for submitting a CAP; and*
- *the provider or supplier's appeal rights, procedures for requesting a Medicare contractor reconsideration, and the address to which the written appeal must be mailed.*

Corrective Actions Plan (CAP)

A CAP is the process that gives the provider or supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges. The CAP should provide evidence that the provider or supplier is in compliance with Medicare requirements.

The *Medicare* contractor, including the NSC, shall accept, for review, the submission of a CAP for denied or revoked billing privileges if the CAP is submitted within 30 days from the date of the notice for providers and suppliers or 15 days from the date of the notice for DMEPOS suppliers. Submission of a CAP shall contain, at a minimum, verifiable evidence of provider or supplier compliance with enrollment requirements.

If a CAP for a denied application *or revoked billing privileges* is approved by a *Medicare* contractor, billing privileges can be issued. *The effective date is based on the date the provider or supplier came into compliance with all Medicare requirements. For DMEPOS suppliers the effective date is the date it is awarded by the NSC.* CMS' approval is required prior to restoring billing privileges.

The *Medicare* 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 in order to accept any appeal that has been submitted beyond the timely filing period.

NOTE: If a CAP and a reconsideration request (i.e., appeal request) are submitted concurrently, the *Medicare* contractor shall first process and make a determination on the CAP. *The reconsideration request should then be processed by a Hearing Officer (HO) unrelated to the initial determination or CAP to ensure the applicant receives an independent review of their reconsideration.* The *Medicare* contractor and the HO shall coordinate 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 shall be sent to the provider or supplier acknowledging enrollment into Medicare and that their reconsideration request should be withdrawn. If the CAP is denied, the provider or supplier shall be notified by letter and may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request.

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. *Medicare* contractors shall

extend the filing period an additional 5 days to allow for mail time. Reconsideration requests submitted on the 65th day or the 95th day of which falls on a weekend or holiday should still be considered timely filed and not rejected. The date the request is received by the *Medicare* 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.

Medicare contractor reconsiderations shall be conducted by a *HO* or senior staff having expertise in provider enrollment and who *was* independent from the initial decision to deny or revoke enrollment.

NOTE: The NSC reconsiderations *shall be* conducted by a HO.

Upon receipt of the reconsideration, the HO shall send a letter to the provider or supplier to acknowledge receipt of their request. In its 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 its acknowledgment letter in the reconsideration file.

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

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

If a request for reconsideration is filed late, the HO shall make a finding of good cause before taking any other action on the appeal. The 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 shall issue a written decision *within* 90 days from the date of the request and forward the decision to the *Medicare* contractor and by certified mail to the provider, supplier or the authorized representative. The reconsideration letter *shall* include:

- the re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in their initial determination;
 - *A summary of the documentation submitted by the prospective provider/supplier or the enrolled provider/supplier;*
 - a clear explanation of why the HO is upholding or overturning the denial or revocation action *in sufficient detail for the provider or supplier to understand the nature of its deficiencies;*
 - if applicable, the regulatory basis to support each reason or reasons for the denial *or revocation;*
 - an explanation of how the provider or supplier does not meet the enrollment criteria or requirements to enroll;
 - *further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the address to which the written appeal must be mailed; and*
 - information the appellant must include with their appeal (*name/legal business name*, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision).

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 the reconsideration action will be terminated.

Medicare 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 or requests withdrawn). *Medicare* contractors are not required to submit this information to CO but it must be provided upon request.

Administrative Law Judge (ALJ) Hearing

The CMS, a Medicare contractor, or a provider or 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

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 DAB will issue a letter by certified mail to the provider or supplier, CMS *central office (CO)* 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 that will represent CMS during the appeals process and *who will* also serve as the DAB point of contact. *Neither* CMS or 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* 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 addressed with CMS.

Departmental Appeals Board (DAB) Hearing

The CMS, a Medicare contractor, or a provider or supplier dissatisfied with the ALJ hearing decision may request Board review by the DAB. *Such request must be filed* 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 *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, then a transcript will be prepared and made available to any party upon request.

Judicial Review

A 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. *Such request shall be filed within 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 supplier and finds that the application should 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, the *Medicare* contractor *shall deny/recommend denial to the regional office (RO) and notify the provider or certified supplier by letter. The denial letter shall contain:*

- *the reason for the denial in sufficient detail to allow the provider or certified supplier to understand the nature of its deficiencies;*
- a regulatory basis to support each reason or reasons for the denial;
- *procedures for submitting a corrective action plan (CAP); and*
- *the provider or certified supplier's appeal rights, procedures for requesting an RO reconsideration and the address to which the written appeal must be mailed.*

Similarly, when a *Medicare* contractor discovers that there is a basis for revoking a provider or certified supplier's billing privileges, such as *the* provider or certified supplier no longer meets one of the requirements for billing privileges, the *Medicare contractor shall revoke* billing privileges *and notify the provider or certified supplier by letter with a copy to the State and the RO.* The revocation letter must contain:

- *the reason for the revocation in sufficient detail for the provider or certified supplier to understand the nature of its deficiencies;*
- the regulatory basis to support each reason or reasons for the revocation;
- the effective date of the revocation (30 days from the date the notice is mailed. *A revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment. The effective date of a license suspension/revocation is effective with the date of the suspension/revocation);*
- *procedures for submitting a CAP; and*
- *the provider or certified supplier's appeal rights, procedures for requesting an RO reconsideration, and the address to which the written appeal must be mailed.*

Corrective Action Plan (CAP)

A CAP is the process that gives the provider or certified supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial or revocation of billing

privileges. The CAP should provide evidence that the provider or *certified* supplier is in compliance with Medicare requirements.

The *Medicare* contractor/RO shall accept, for review, the submission of a CAP for denied or revoked billing privileges if the CAP is submitted within 30 days from the date of the notice. Submission of a CAP shall contain, at a minimum, verifiable evidence of the provider or certified supplier's compliance with enrollment requirements.

If a CAP for a denied application *or revoked billing privileges* is approved by the *Medicare contractor/RO*, billing privileges can be issued. *The effective date is based on the date the provider or certified supplier came into compliance with all Medicare requirements. That is, once the provider or certified supplier has passed the state survey and been issued a certification date. CMS approval is required prior to restoring billing privileges.*

The *Medicare* contractor/RO shall process a CAP within 60 days. During this process, the *Medicare* contractor/RO shall not toll the filing requirements associated with an appeal. However, the *Medicare* contractor/RO can make a good cause determination in order to accept any appeal that has been submitted beyond the timely filing period.

NOTE: If a CAP and a reconsideration request (i.e., appeal request) are submitted concurrently, the *Medicare contractor/RO shall first process and make a determination on the CAP. The reconsideration request should then be processed by the RO unrelated to the initial determination or CAP to ensure the applicant receives an independent review of their reconsideration.* The *Medicare* contractor and the RO shall coordinate 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 shall be sent to the provider or certified supplier acknowledging enrollment into Medicare and that their reconsideration request should be withdrawn. If the CAP is denied, the provider or certified supplier shall be notified by letter and may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request.

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 RO shall extend the filing period an additional 5 days to allow for mail time. Reconsideration requests submitted on the 65th day of which falls on a weekend or holiday shall still be considered timely filed and not rejected. 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 a 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 *within* 90 days from the date of the request. The RO shall include a copy of its acknowledgment letter in the reconsideration file.

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

In reviewing an initial enrollment decision or a revocation, *the* RO should limit the scope of its review to the *Medicare* contractor/RO's initial reason for imposing a denial or revocation at the time that it issued the action and whether the *Medicare* contractor/RO made the correct decision (i.e., denial/revocation). The *Medicare* contractor/RO 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 or certified 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 its review.

If a reconsideration request is filed late, the RO shall make 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 shall issue a written decision *within* 90 days from the date of the request and forwards the decision by certified mail to the *Medicare* contractor, the provider, certified supplier or the authorized representative. The reconsideration letter *shall* include:

- the re-stated facts and findings, including regulatory basis for the action as determined by the *Medicare contractor/RO* in their initial determination;
- *A summary of the documentation submitted by the prospective provider/supplier or the enrolled provider/supplier;*
- a clear explanation of why the RO is upholding or overturning the denial or revocation action *in sufficient detail for the provider or certified supplier to understand the nature of its deficiencies;*
- if applicable, the regulatory basis to support each reason or reasons for the denial or revocation;

- an explanation of how the provider or certified supplier does not meet the enrollment criteria or requirements to enroll;
 - *further appeal rights, procedures for requesting an ALJ hearing, and the address to which the written appeal must be mailed; and*
 - information the appellant must include with their appeal (*name/legal business name*, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision).

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 the 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 or requests withdrawn). The RO is not required to submit this information to CO but it must be provided upon request.

ALJ Hearing

The CMS, a Medicare contractor, or a provider or certified supplier dissatisfied with a reconsidered determination is entitled to a hearing before the 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 the receipt of the reconsideration decision. ALJ requests should be sent to:

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Failure to timely request the 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 certified supplier, *CMS central office (CO), the RO and the RO of General Counsel (OGC)* acknowledging receipt of an appeals request and detailing a scheduled prehearing conference. The OGC

will assign an attorney that will represent CMS during the appeal's process and *who* will *also* serve as the DAB point of contact. *Neither* CMS, the RO, or 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. Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS.

DAB Hearing

The CMS, a Medicare contractor, or a provider or certified supplier dissatisfied with the ALJ *hearing* decision *may request Board review* by the DAB. *Such request* must *be* filed 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 *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 then a transcript will be prepared and made available to any party upon request.

Judicial Review

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