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| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 936 | Date: January 31, 2020 |
| | Change Request 11210 |

SUBJECT: Provider Enrollment Appeals Procedure

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update provider enrollment policy regarding Corrective Action Plans (CAPs) and/or reconsideration requests in Chapter 15 of Publication (Pub.) 100-08. This CR will also update applicable model letters, including initial determinations, to include the appropriate review rights for the provider and/or supplier.

EFFECTIVE DATE: May 1, 2020

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

IMPLEMENTATION DATE: May 1, 2020

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/Table of Contents |
| R | 15/15.24/15.24.7/15.24.7.1/Model Approval Letter |
| R | 15/15.24/15.24.8/15.24.8.1/Model Denial Letter |
| R | 15/15.24/15.24.9/15.24.9.1/Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers |
| N | 15/15.24/15.24.9/15.24.9.2/Model Revocation Letter for National Supplier Clearinghouse (NSC) |
| R | 15/15.24/15.24.10/Reserved for Future Use |
| R | 15/15.24/15.24.10/15.24.10.1/CAP Withdrawn Acknowledgement Template |
| R | 15/15.24/15.24.10/15.24.10.2/CAP Receipt Acknowledgement Template to Provider/Supplier/Representative |
| R | 15/15.24/15.24.10/15.24.10.3/CAP Decision Email Template to Provider/Supplier/Representative |
| R | 15/15.24/15.24.10/15.24.10.4/CAP Not Actionable (Moot) Model Letter |
| R | 15/15.24/15.24.10/15.24.10.5/Untimely CAP Dismissal Model Letter |
| N | 15/15.24/15.24.10/15.24.10.6/Improperly Signed CAP Dismissal Model Letter |
| N | 15/15.24/15.24.10/15.24.10.7/No CAP Rights Dismissal Model Letter |
| N | 15/15.24/15.24.10/15.24.10.8/Not Eligible to Submit CAP Dismissal Model Letter |
| N | 15/15.24/15.24.10/15.24.10.9/CAP Signature Development Model Letter |
| R | 15/15.24/15.24.10/15.24.10.10/Favorable CAP Model Letter in Response to an Enrollment Denial |
| N | 15/15.24/15.24.10/15.24.10.11/Favorable CAP Model Letter for Revocation Determination |
| N | 15/15.24/15.24.10/15.24.10.12/Unfavorable CAP Model Letter in Response to an Enrollment Denial |
| N | 15/15.24/15.24.10/15.24.10.13/Unfavorable CAP Model Letter for Revocation Determination |
| N | 15/15.24/15.24.10/15.24.10.14/CAP Further Information Required for Development Model Letter |
| R | 15/15.24/15.24.11/Reserved for Future Use |
| N | 15/15.24/15.24.11/15.24.11.1/Reconsideration Request Withdrawn Acknowledgement Template |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|--------------|---|
| N | 15/15.24/15.24.11/15.24.11.2/Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative |
| N | 15/15.24/15.24.11/15.24.11.3/Reconsideration Request Decision Email Template to Provider/Supplier/Representative |
| N | 15/15.24/15.24.11/15.24.11.4/Reconsideration Request Not Actionable (Moot) Model Letter |
| N | 15/15.24/15.24.11/15.24.11.5/Untimely Reconsideration Request Dismissal Model Letter |
| N | 15/15.24/15.24.11/15.24.11.6/Improperly Signed Reconsideration Request Dismissal Model Letter |
| N | 15/15.24/15.24.11/15.24.11.7/Not Eligible to Submit Reconsideration Request Dismissal Model Letter |
| N | 15/15.24/15.24.11/15.24.11.8/Reconsideration Request Signature Development Model Letter |
| N | 15/15.24/15.24.11/15.24.11.9/Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial |
| N | 15/15.24/15.24.11/15.24.11.10/Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination |
| N | 15/15.24/15.24.11/15.24.11.11/Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation) |
| N | 15/15.24/15.24.11/15.24.11.12/Favorable Reconsideration Request Model Letter for Revocation Determination |
| N | 15/15.24/15.24.11/15.24.11.13/Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial |
| N | 15/15.24/15.24.11/15.24.11.14/Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination |
| N | 15/15.24/15.24.11/15.24.11.15/Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation) |
| N | 15/15.24/15.24.11/15.24.11.16/Unfavorable Reconsideration Request Model Letter for Revocation Determination |
| N | 15/15.24/15.24.11/15.24.11.17/Reconsideration Further Information Required for Development Model Letter |
| R | 15/15.25/Review Procedures for Determinations that Affect Participation in the Medicare Program |
| R | 15/15.25/15.25.1/Corrective Action Plans (CAPs) |
| D | 15/15.25/15.25.1/15.25.1.1/Corrective Action Plans (CAPs) |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|-------|---|
| D | 15/15.25/15.25.1/15.25.1.2/Reconsideration Requests - Non-Certified Providers/Suppliers |
| D | 15/15.25/15.25.1/15.25.1.3/Additional Appeal Levels |
| R | 15/15.25/15.25.2/Reconsideration Requests |
| D | 15/15.25/15.25.2/15.25.2.1/Corrective Action Plans (CAPs) |
| D | 15/15.25/15.25.2/15.25.2.2/Reconsideration Requests - Certified Providers and Certified Suppliers |
| D | 15/15.25/15.25.2/15.25.2.3/Additional Appeal Levels |
| N | 15/15.25/15.25.3/Further Appeal Rights for Reconsidered Determinations |
| N | 15/15.25/15.25.4/External Reporting Requirements for CAPs and Reconsideration Requests |
| R | 15/15.27/15.27.4/External Reporting Requirements |

III. FUNDING:

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**

Attachment - Business Requirements

| | | | |
|--------------------|-------------------------|-------------------------------|------------------------------|
| Pub. 100-08 | Transmittal: 936 | Date: January 31, 2020 | Change Request: 11210 |
|--------------------|-------------------------|-------------------------------|------------------------------|

SUBJECT: Provider Enrollment Appeals Procedure

EFFECTIVE DATE: May 1, 2020

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

IMPLEMENTATION DATE: May 1, 2020

I. GENERAL INFORMATION

A. Background: This CR will update the provider enrollment policy regarding Corrective Action Plans (CAPs) and reconsideration requests in Chapter 15 of Pub. 100-08. This CR will also update applicable model letters, including initial determination letters, to advise providers and/or suppliers of the appropriate rights to review.

B. Policy: There are no legislative or regulatory impacts associated with this CR.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

| Number | Requirement | Responsibility | | | | | | | | Other |
|---------|---|----------------|---|---------|--------------------------------|------------------------------|---------|---------|---------|---------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| 11210.1 | MACs shall forward all CAPs and reconsideration requests received to ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt for the following reasons: (1) submitted on behalf of a certified provider/supplier as defined in 15.4; (2) submitted on behalf of an independent diagnostic testing facility; (3) submitted on behalf of an Opioid Therapy Program; (4) submitted on behalf of a Medicare Diabetes Prevent Program; (5) submitted in response to an enrollment denial pursuant, in whole or in part, to 42 Code of Federal Regulations § 424.530(a)(2), (3), (6), (11), (12), (13), and (14); (6) submitted in | X | X | X | | | | | | NS C |

| Number | Requirement | Responsibility | | | | | | | | |
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| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
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| | regarding the entering of CAP/Appeal Information in Section 3. | | | | | | | | | |
| 11210.3 | If MACs receive an enrollment application for a provider or supplier while a CAP and/or reconsideration request is pending or during the timeframe in which a provider or supplier is eligible to submit a CAP and/or reconsideration request for an enrollment denial or revocation, the MAC shall return the application in accordance with 15.25(H). | | X | | | | | | NS C | |
| 11210.4 | Once a CAP and/or reconsideration decision is issued, MACs shall not reopen, revise or reissue a decision without CMS's prior approval. | | X | | | | | | NS C | |
| 11210.5 | MACs shall work with and provide CMS and the Office of General Counsel (OGC), when applicable, all necessary documentation related to any and all CAPs, reconsideration requests, Administrative Law Judge (ALJ) appeals, Departmental Appeals Board (DAB) appeals, and/or requests for judicial review. | | X | | | | | | NS C | |
| 11210.5.1 | MACs shall supply CMS and/or OGC with all requested documentation within 5 business days of receipt of the request, unless requested sooner. | | X | | | | | | NS C | |
| 11210.5.2 | MACs shall save all documentation provided to CMS and/or OGC in PDF | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|-----------|---|----------------|---|---------|--------------------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| | format if applicable and include a description of the file content in the file name. | | | | | | | | | |
| 11210.6 | If a CAP and/or reconsideration decision, ALJ decision, DAB decision, or settlement agreement requires the MAC to take action on a provider's or supplier's enrollment record, the MAC shall complete all necessary updates to the enrollment record within 10 business days of the date of the decision if issued by the MAC or the date of receipt of instruction from CMS unless additional information/documentation is required to complete the updates, then the MAC shall complete within 10 business days of the date of receipt of the necessary additional documentation. | | X | | | | | | NS C | |
| 11210.6.1 | MACs shall send confirmation to ProviderEnrollmentAppeals@cms.hhs.gov when the enrollment record has been updated in response to a CAP and/or reconsideration decision, ALJ/DAB decision, or settlement agreement within 1 business day of the update being completed if the request to update the enrollment originated from CMS. | | X | | | | | | NS C | |
| 11210.6.2 | If a CAP and/or reconsideration decision, ALJ decision, DAB decision or settlement requires the provider or supplier to submit further information before enrollment record can be | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|-------------|---|----------------|---|---------|----------------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
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| | updated, MACs shall allow 30 calendar days for the provider or supplier to submit the additional information. | | | | | | | | | |
| 11210.6.2.1 | If the provider or supplier does not submit the necessary information within 30 calendar days, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov for further instruction within 5 business days of the end of the 30 calendar days. | | X | | | | | | NS C | |
| 11210.6.2.2 | MACs shall update the enrollment record within 10 business days of processing and/or approving requested additional information and/or documentation. | | X | | | | | | NS C | |
| 11210.7 | MACs shall review all CAP and reconsideration requests to determine if they were submitted timely. | | X | | | | | | NS C | |
| 11210.7.1 | MACs shall ensure that all CAPs were received within 35 days of the date of the initial determination letter and that all reconsideration requests were received within 65 days of the date of the initial determination letter to be considered timely. | | X | | | | | | NS C | |
| 11210.7.2 | If MACs receive an untimely CAP and/or reconsideration request that it believes is entitled to a good cause exception related to untimeliness, the MACs shall submit a request for approval from ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of determining | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|-----------|--|----------------|---|---------|--------------------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
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| | the submission is untimely with an explanation as to why good cause is believed to exist before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. | | | | | | | | | |
| 11210.7.3 | MACs shall dismiss all CAPs and reconsideration requests that are not timely submitted and for which no good cause exception related to untimeliness has been approved by CMS, using the applicable dismissal model letter. | | X | | | | | | NS C | |
| 11210.8 | MACs shall ensure that all CAPs and/or reconsideration requests specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement. | | X | | | | | | NS C | |
| 11210.8.1 | MACs shall dismiss all CAPs and/or reconsideration requests that do not specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement. | | X | | | | | | NS C | |
| 11210.9 | MACs shall ensure that all CAPs and reconsideration requests are signed by the individual provider, supplier, authorized or delegated official listed on the Medicare enrollment record, or properly appointed representative. | | X | | | | | | NS C | |
| 11210.9.1 | MACs shall ensure that all representatives that are | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|-------------|---|----------------|---|---------|--------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| | attorneys include a statement that he or she has the authority to represent the provider or supplier in order to qualify as a proper signature of a representative on behalf of the individual provider or supplier. | | | | | | | | | |
| 11210.9.2 | MACs shall ensure that the individual provider, supplier, or authorized or delegated official listed on the Medicare enrollment record files written notice that is signed by the individual provider, supplier, or authorized or delegated official of the appointment of a non-attorney representative in order to qualify as a proper signature. | | X | | | | | | NS C | |
| 11210.9.3 | If a CAP and/or reconsideration request is not appropriately signed or if a statement from the attorney or written notice of appointment of a non-attorney representative is not included in the submission, the MAC shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the CAP and/or reconsideration request as not properly signed. | | X | | | | | | NS C | |
| 11210.9.3.1 | The MAC shall allow 15 calendar days from the date of the development request letter for the CAP and/or reconsideration request submitter to respond to the development request. | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|------------------|---|----------------|---|---------|----------------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| | disagreement, and is submitted in response to a denial or revocation under 42 C.F.R. § 424.530(a)(1) and/or 42 C.F.R. § 424.535(a)(1). | | | | | | | | | |
| 11210.12.1 | For all accepted CAPs, MACs shall send a receipt acknowledgement hard-copy letter and email (if a valid email address is available) to the individual that submitted the CAP within 14 calendar days of the date of receipt using the applicable model letter unless a CAP decision is issued within 14 calendar days of the date of receipt. | | X | | | | | | NS C | |
| 11210.12.1 .1 | For all accepted CAPs, MACs should also send a receipt acknowledgement via fax if a valid fax number is available unless a CAP decision is issued within 14 calendar days of the date of receipt. | | X | | | | | | NS C | |
| 11210.12.1 .2 | MACs shall not send a receipt acknowledgement letter and email for CAPs that are dismissed. | | X | | | | | | NS C | |
| 11210.12.2 | MACs shall accept all supplemental submissions for accepted CAPs up to the date the decision is issued. | | X | | | | | | NS C | |
| 11210.13 | MACs shall process and render a decision for all accepted CAPs not required to be forwarded to CMS within 60 calendar days of the date of receipt of the accepted CAP submission, using the applicable CAP model letter. | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|--------------------|---|----------------|---|---------|--------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| | with standard processing procedures. | | | | | | | | | |
| 11210.16.2 | If the revocation is overturned in its entirety by the CAP decision, then the MAC shall reinstate the provider's or suppliers enrollment to an approved status based on the date the provider or supplier came into compliance. | | X | | | | | | NS C | |
| 11210.16.2 .1 | MACs shall modify the provider's or supplier's Medicare enrollment record in accordance with the CAP decision within 10 business days of the date the decision is issued. | | X | | | | | | NS C | |
| 11210.16.2 .2 | MACs shall denote in its CAP decision letter if any additional information/documentation or action is required from the provider or supplier prior to making modification(s) to the provider's or supplier's Medicare enrollment record. | | X | | | | | | NS C | |
| 11210.16.2 .3 | If the additional information/documentation is not received within 30 calendar days of the date of the CAP decision, the MACs shall send the CAP Further Information Required for Development model letter to the provider or supplier via hard-copy mail and email if available within 10 calendar days of not receiving a response to again request the additional information. | | X | | | | | | NS C | |
| 11210.16.2 .3.1 | MACs should also contact the provider or supplier via phone if a valid phone | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
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| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | | Oth er |
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| | reconsideration request via hard-copy letter and email (if a valid email address is available) within 14 calendar days of the date of receipt of the reconsideration request unless a reconsideration decision is issued within 14 calendar days of the date of receipt of the reconsideration request. | | | | | | | | | |
| 11210.19.1 | For all accepted reconsideration requests, MACs should also send a receipt acknowledgement letter via fax if a valid fax number is available unless a reconsideration decision is issued within 14 calendar days of the date of receipt of the reconsideration request. | | X | | | | | | NS C | |
| 11210.20 | If the individual provider, supplier, authorized or delegated official, or properly appointed representative files a written request to withdraw a reconsideration request with the MAC prior to a decision being issued, the MAC shall use the applicable model letter to acknowledge receipt of the request and advise that the reconsideration request has been withdrawn and a decision will not be rendered. | | X | | | | | | NS C | |
| 11210.21 | MACs shall process and render a decision for all accepted reconsideration requests not required to be forwarded to CMS within 90 calendar days of the date of receipt of the reconsideration request using the applicable model letter. | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|--------------|---|----------------|---|---------|--------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D ME M AC | Shared-System Maintainers | | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| | unfavorable model letter. | | | | | | | | | |
| 11210.25 | MACs shall denote in its reconsideration decision letter if any additional documentation/information or action is required from the provider or supplier prior to making modification(s) to the provider's or supplier's Medicare enrollment record. | | X | | | | | | NS C | |
| 11210.26 | If the additional documentation/information is not received within 30 calendar days of the date of the reconsideration decision, the MACs shall send the Reconsideration Further Information Required for Development model letter to the provider or supplier via hard-copy mail and email if available within 10 calendar days of not receiving a response to again request the additional documentation/information. | | X | | | | | | NS C | |
| 11210.26.1 | MACs should also contact the provider/supplier via phone if a valid phone number is available regarding the required additional documentation/information. | | X | | | | | | NS C | |
| 11210.26.1.1 | If no response is received within 30 calendar days of the second request, the MACs shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days of not receiving a response to the second request for further instruction. | | X | | | | | | NS C | |
| 11210.27 | If the MAC receives a CAP and/or reconsideration | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
|----------|--|----------------|---|---------|--------------------------------|------------------------------|---------|---------|---------|-----------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
| | | A | B | HH H | | FI SS | M CS | V MS | C WF | |
| | request in response to an initial determination that has since been rescinded, revised and reissued, or otherwise modified, the MAC shall issue a letter to the individual that submitted the CAP and/or reconsideration request using the applicable not actionable model letter. | | | | | | | | | |
| 11210.28 | If the MAC encounters a situation that is not addressed by this instruction, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov for further instruction before taking any action regarding the submission or enrollment record. | | X | | | | | | NS C | |
| 11210.29 | MACs shall use only the provided model letters. | X | X | X | | | | | NS C | |
| 11210.30 | MACs shall save and send all letters (when using email) associated with this CR in PDF format. | X | X | X | | | | | NS C | |
| 11210.31 | MACs shall send all CAP and reconsideration decisions on the date that is on the decision letter. | | X | | | | | | NS C | |
| 11210.32 | MACs shall ensure that the applicable CMS Regional Office is notified of the outcome of any CAP and/or reconsideration decision that involves the revocation of Medicare billing privileges for a certified provider or supplier. | X | X | X | | | | | | |
| 11210.33 | MACs shall use the coversheet provided if the MACs choose to utilize a coversheet, but a coversheet | | X | | | | | | NS C | |

| Number | Requirement | Responsibility | | | | | | | | |
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| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Oth er |
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| | is optional. | | | | | | | | | |
| 11210.34 | MACs shall record all CAPs and reconsideration requests (regardless if the decision was issued by the MACs or CMS) in the Provider Enrollment Chain and Ownership System (PECOS). | | X | | | | | | NS C | |
| 11210.35 | MACs shall record all CAPs and reconsideration requests on MAC Monthly Appeals Reporting Template. | | X | | | | | | NS C | |
| 11210.35.1 | MACs shall complete all columns on the MAC Monthly Appeals Reporting Template for each CAP and reconsideration request. | | X | | | | | | NS C | |
| 11210.36 | MACs shall send a monthly report of the MAC Monthly Appeals Reporting Template to ProviderEnrollmentAppeals@cms.hhs.gov, no later than the 15th of each month. | | X | | | | | | NS C | |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|----------|---|----------------|---|-----|------------|------|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 11210.37 | MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your | X | X | X | | |

| Number | Requirement | Responsibility | | | | |
|--------|---|----------------|---|-----|------------|------|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter. | | | | | |

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

| 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): Timothy Trego, 410-786-8976 or timothy.trego@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 3

Medicare Program Integrity Manual

Chapter 15 - Medicare Enrollment

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 - 15.24.10.2 – *CAP Receipt Acknowledgement Template to Provider/Supplier/Representative*
 - 15.24.10.3 – *CAP Decision Email Template to Provider/Supplier/Representative*
 - 15.24.10.4 – *CAP Not Actionable (Moot) Model Letter*
 - 15.24.10.5 – *Untimely CAP Dismissal Model Letter*
 - 15.24.10.6 – *Improperly Signed CAP Dismissal Model Letter*
 - 15.24.10.7 – *No CAP Rights Dismissal Model Letter*
 - 15.24.10.8 – *Not Eligible to Submit CAP Dismissal Model Letter*
 - 15.24.10.9 – *CAP Signature Development Model Letter*
 - 15.24.10.10 – *Favorable CAP Model Letter in Response to an Enrollment Denial*
 - 15.24.10.11 – *Favorable CAP Model Letter for Revocation Determination*
 - 15.24.10.12 – *Unfavorable CAP Model Letter in Response to an Enrollment Denial*
 - 15.24.10.13 – *Unfavorable CAP Model Letter for Revocation Determination*
 - 15.24.10.14 – *CAP Further Information Required for Development Model Letter*
- 15.24.11 – *Reserved for Future Use*
 - 15.24.11.1 – *Reconsideration Request Withdrawn Acknowledgement Template*
 - 15.24.11.2 – *Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative*
 - 15.24.11.3 – *Reconsideration Request Decision Email Template to Provider/Supplier/Representative*
 - 15.24.11.4 – *Reconsideration Request Not Actionable (Moot) Model Letter*
 - 15.24.11.5 – *Untimely Reconsideration Request Dismissal Model Letter*
 - 15.24.11.6 – *Improperly Signed Reconsideration Request Dismissal Model Letter*
 - 15.24.11.7 – *Not Eligible to Submit Reconsideration Request Dismissal Model Letter*
 - 15.24.11.8 – *Reconsideration Request Signature Development Model Letter*
 - 15.24.11.9 – *Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial*
 - 15.24.11.10 – *Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination*
 - 15.24.11.11 – *Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)*
 - 15.24.11.12 – *Favorable Reconsideration Request Model Letter for Revocation Determination*
 - 15.24.11.13 – *Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial*
 - 15.24.11.14 – *Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination*

- 15.24.11.15 – Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)*
- 15.24.11.16 – Unfavorable Reconsideration Request Model Letter for Revocation Determination*
- 15.24.11.17 – Reconsideration Further Information Required for Development Model Letter*
- 15.25 – Review Procedures for Determinations that Affect Participation in the Medicare Program*
 - 15.25.1 – Corrective Action Plans (CAPs)*
 - 15.25.2 – Reconsideration Requests*
 - 15.25.3 – Further Appeal Rights for Reconsidered Determinations*
 - 15.25.4 – External Reporting Requirements for CAPs and Reconsideration Requests*

15.24.7.1 Model Approval Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

We are pleased to inform you that your [initial Medicare enrollment application]/[revalidated Medicare enrollment application]/[change of information request] is approved. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an “other” provider identification number to the National Plan and Provider Enumeration System (NPPES).

Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

If you plan to file claims electronically, please contact our EDI department at [phone number].

Medicare Enrollment Information

Provider \ Supplier name: [Name]

National Provider Identifier (NPI): [NPI]

Provider Transaction Access Number (PTAN): [PTAN]

Specialty: [Provider specialty]

You are a: [participating]/[non-participating]

Effective date: [Effective date]

Medicare Year-End Cost Report date: [Date]

Changed Information: [List all updates/changes]

Please verify the accuracy of your enrollment information.

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to [42 C.F.R. § 424.516 or 42 C.F.R. § 424.205]. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) [practice location or administrative locations and/or community settings], (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS).

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert contractor's web address].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]]] with your submission.]

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|----|--|
| [Name of MAC] | or | [Centers for Medicare & Medicaid Services] |
| [Address] | | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or

Sincerely,

[Name]

[Title]

[Company]

15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[Month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: *(Only if revoked under 42 C.F.R. § 424.535(a)(1))*

*You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.*

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- *Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;*

- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*
- *Provide evidence to demonstrate that you are in compliance with Medicare requirements.*

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | |
|-------------------------|---|
| <i>[Name of MAC]</i> | <i>[Centers for Medicare & Medicaid Services]</i> |
| <i>[Address]</i> | <i>[Provider Enrollment & Oversight Group]</i> |
| <i>[City], ST [Zip]</i> | <i>[ATTN: Division of Compliance & Appeals]</i> |
| | <i>[7500 Security Blvd.]</i> |
| | <i>[Mailstop: AR-19-51]</i> |
| | <i>[Baltimore, MD 21244-1850]</i> |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the*

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Certified mail number: [number]

Returned receipt requested

Dear [Provider/Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the CMS 855S enrollment application. The 30day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.579(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare

for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (A) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

*You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.*

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- *Be received in writing within 35 calendar days of the date of this letter and mailed and/or emailed to the address below;*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*
- *Provide evidence to demonstrate that you are in compliance with Medicare requirements.*

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

*[Name of MAC]
[Address]
[City], ST [Zip]*

or

*[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]*

[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed and/or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
 - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
 - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
 - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*
- *(If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

Hard-Copy Letter Template

*[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]*

*Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)*

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

**15.24.10.2 - CAP Receipt Acknowledgement Email Template to
Provider/Supplier/Representative**
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely

,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

***15.24.10.3 - CAP Decision Email Template to Provider/Supplier/Representative
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)***

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the CAP]*

Subject: *Medicare Provider Enrollment CAP re: [Provider/Supplier Name]*

(Be sure to attach a copy of the final decision[s] in PDF format.)

Dear [Name of the person(s) who submitted the CAP]:

Please see the attached decision regarding your Medicare Provider Enrollment CAP.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

15.24.10.4 - CAP Not Actionable (Moot) Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the CAP is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be

electronic) [Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.10.5 - Untimely CAP Dismissal Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

[Address] (Address from which the CAP was sent)

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A CAP must be received within 35 calendar days of the date of the initial determination letter. Your CAP was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame.

[Provider/Supplier/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.10.6 – Improperly Signed CAP Dismissal Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement was stated in the initial determination letter, dated [Month] [DD], [YYYY], as well as in Chapter 15 of the Medicare Program Integrity Manual.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.7 – No CAP Rights Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent)
[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP. A provider or supplier may only submit a CAP if there has been a denial of enrollment in the Medicare program under 42 C.F.R § 424.530(a)(1) or the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). Your enrollment was not denied or revoked under one of the aforementioned authorities. Therefore, a CAP decision cannot be rendered based on this submission.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

***15.24.10.8 – Not Eligible to Submit CAP Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)***

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP]

[Address](Address from which the CAP was sent)

[City], [State] [Zip Code]

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the [corrective action plan (CAP)] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [CAP] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights extend only to initial determinations related to the denial or revocation of Medicare billing privileges.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.9 – CAP Signature Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP] (If submitted on behalf of an organization or group)

[Address] (Address from which the CAP was sent)

[City], [State] [Zip Code]

Re: Corrective Action Plan Submission

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your CAP submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as stated in the initial determination letter and in the Medicare Program Integrity Manual, Ch. 15, Section 15.25. [MAC Name] is requesting that you submit a CAP that is properly signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a CAP that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mailed to the following address:

*[MAC Appeal Receipt Address]
[MAC Fax number]*

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.10.10 – Favorable CAP Model Letter in Response to an Enrollment Denial

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

*[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent)
[City], [State] [Zip Code]*

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received on [Month] [DD], [YYYY]; therefore, this CAP is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)*

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15, section 15.XX)*

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial was overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement. Approval date should be based on the date the provider or supplier came into compliance with all applicable Medicare requirements.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license expired. However, on [Month] [DD], [YYYY] John Smith submitted a copy of his renewed medical license, which was reinstated back to the date of expiration by the Wisconsin Medical Board. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.*

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

**15.24.10.11 - Favorable CAP Model Letter for Revocation Determination
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

*[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent)
[City], [State] [Zip Code]*

*Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)*

Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON:

- *42 C.F.R. § 424.535(a)(1)*

OTHER APPLICABLE AUTHORITIES:

- *(Ex: Medicare Program Integrity Manual chapter 15, section 15.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld or overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory basis to support the revocation for noncompliance, and an explanation of how the provider or supplier now meets the enrollment compliance criteria or requirements. This section shall not reference a CAPdecision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was suspended. However, as part of her CAP, Jane Doe submitted a revised order from the Wisconsin Medical Board, which reinstated her medical back license back to the date of suspension. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].*

(The reinstatement date is based on chapter 15 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

***15.24.10.12 – Unfavorable CAP Model Letter in Response to an Enrollment Denial
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)***

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

*[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent)
[City], [State] [Zip Code]*

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)*

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15.XX)*

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP).

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe’s medical license was suspended by the Wisconsin Medical Board. [MAC Name] has confirmed that Jane Doe’s medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe’s Medicare enrollment application under 42 C.F.R. § 424.530(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP does not correct the deficiencies that led to the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.*

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.10.13 – Unfavorable CAP Model Letter for Revocation Determination
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

*[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent)
[City], [State] [Zip Code]*

*Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)*

Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good

cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance. If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support compliance and how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that her medical license has been reinstated. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP did not correct the deficiencies noted in the implementation of the revocation. As a result, the revocation of your Medicare billing privileges is upheld.*

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]

[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.10.14 – CAP Further Information Required for Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the CAP.]*

Subject: *Medicare Provider Enrollment CAP re: [Provider/Supplier Name]*

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP] (If submitted on behalf of an organization or group)

[Address] (Address from which the CAP was sent)

[City], [State] [Zip Code]

Re: CAP Decision

Legal Business Name: *[Provider/Supplier Name] (as it appears in PECOS)*

NPI: *[XXXXXXXXXXXX]*

PTAN: *[XXXXXX]*

Reference Number: *[XXXX] (Internal Tracking)*

Dear [Name of the person(s) who submitted the CAP]:

On [Month] [DD], [YYYY], [MAC Name] issued a CAP decision. As stated in the [Month] [DD], [YYYY] CAP decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC CAP Receipt Address]

[MAC CAP Receipt Email Address]

[MAC CAP Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.11 – Reserved for Future Use

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

15.24.11.1 – Reconsideration Request Withdrawn Acknowledgement Template

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: *[Email address provided by the person who submitted the reconsideration request]*

Subject: *Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]*

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]

[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.11.2 – Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so

under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.11.3 – Reconsideration Request Decision Email Template to Provider/Supplier/Representative

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the Reconsideration Request]*

Subject: *Medicare Provider Enrollment [Reconsideration Request] re: [Provider/Supplier Name]*

(Be sure to attach a copy of the final decision[s] in PDF format.)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

Please see the attached decision regarding your Medicare Provider Enrollment Reconsideration Request.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.11.4 – Reconsideration Request Not Actionable (Moot) Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of the denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the reconsideration request is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.11.5 – Untimely Reconsideration Request Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the reconsideration request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the initial determination letter dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your reconsideration request as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A reconsideration request must be received within 65 calendar days of the date of the initial determination letter. Your reconsideration request was not received by [MAC Name] until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You have failed to show good cause for your late request. Therefore, [MAC Name] is unable to render a decision in this matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be

electronic) [Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.6 – Improperly Signed Reconsideration Request Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the reconsideration request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination letter.

[MAC Name] is unable to accept your reconsideration request as it was not signed by an

authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 15 of the Medicare Program Integrity Manual.

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing
Officer] [MAC Name]

**15.24.11.7 – Not Eligible to Submit Reconsideration Request Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the [reconsideration request] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [reconsideration request] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights related to provider enrollment extend only from initial determinations.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.8 – Reconsideration Request Signature Development Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request] (If submitted on behalf of an organization or group)

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

We are in receipt of your reconsideration submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 15, Section 15.25. [MAC Name] is requesting that you submit a reconsideration request that is properly signed by the individual provider, supplier, the authorized or delegated official, or a representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC

Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[MAC Fax number]*

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

*[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.11.9 – Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

*[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]*

*Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)*

Dear [Name of the Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.] The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-14)
- 42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], a disciplinary hearing was held regarding the medical license of Jane Doe. However, on [Month] [DD], [YYYY], the Wisconsin Medical Board declined to

take disciplinary action against Jane Doe's medical license. As a result, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;

- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

*[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]*

[MAC Name]

15.24.11.10 – Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] related to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], requesting additional informed needed to process the revalidation application to completion for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, if provided, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex.: On [Month] [DD], [YYYY], John Smith's revalidation application was approved with a gap in his billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. However, as indicated above, [MAC Name] has determined that the reactivation effective should be [Month] [DD], [YYYY]. As a result of the change in the reactivation effective date, the gap in John Smith's Medicare billing privileges has been eliminated.)

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the reactivation effective date for [Provider/Supplier Name].*

You must resubmit any claims that were denied or not previously submitted due to the former gap in your Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. *Clicking Register on the DAB E-File home page;*
2. *Entering the information requested on the “Register New Account” form; and*
3. *Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- *Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:
 - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - *Specifies the basis for contending that the findings and conclusions are incorrect;**
- *The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be

*electronic) [Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

***15.24.11.11 – Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)***

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a determination of the effective date of participation in the Medicare program. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is

considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- *42 C.F.R. § 424.520(a-d)*

OTHER APPLICABLE AUTHORITIES:

- *42 C.F.R. §*
- *(Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the determination of the effective date.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial enrollment application, which was subsequently rejected for failure to timely respond to a development request for additional information/documentation. As part of his reconsideration request, John Smith submitted an email receipt showing that he timely responded to the development request. As a result, [MAC Name] will modify John Smith's Medicare effective date to [Month] [DD],

[YYYY].)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the enrollment effective date to [Month] [DD], [YYYY].

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;**
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be

electronic) [Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.11.12 – Favorable Reconsideration Request Model Letter for Revocation Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

- *42 C.F.R. § 424.535(a)(revocation reason 1-21)*
- *42 C.F.R. § 424.535(a)(revocation reason 1-21)*

OTHER APPLICABLE AUTHORITIES:

- *42 C.F.R. §*
- *(Ex: Medicare Program Integrity Manual chapter 15.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)*
- *Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has reviewed and/or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1- 21).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the provider or supplier arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe’s medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. However, on [Month] [DD] [YYYY], the Wisconsin medical board issued an order reversing the license suspension back to its implementation date based on the outcome of a hearing. As a result, [MAC Name] is overturning the revocation of Jane Doe’s Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

*This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].*

(The reinstatement date is based on chapter 15 of the MPIM and the date of the provider’s or supplier’s revocation or the date the provider’s or supplier’s license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that

this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;**
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name*
- Your Medicare PTAN (if applicable)*
- Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.13 – Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-14)*
- 42 C.F.R. § 424.530(a)(denial reason 1-14)*

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §*
- (Ex: Medicare Program Integrity Manual chapter 15.XX)*

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)*
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the reconsideration request.]

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision

will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe’s medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. Jane Doe did not submit any documentation to demonstrate that her medical license was not suspended. In addition, [MAC Name] has confirmed that Jane Doe’s medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe’s Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- *Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*
 - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights

following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.14 – Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- *Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith's Medicare enrollment was deactivated for failing to timely respond to a revalidation request. On [Month] [DD], [YYYY], John Smith submitted a revalidation application, which was processed and approved. Per the MPIM, Ch. 15, Section 15.29, John Smith's Medicare enrollment was reactivated, but with a gap in his Medicare billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. John Smith's reconsideration request did not demonstrate an error in the determination of his reactivation effective date.)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of a reactivation effective date resulting in a gap in your Medicare billing privileges. As a result, your reactivation effective date will remain [Month] [DD] [YYYY].*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date

of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;**
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name*
- Your Medicare PTAN (if applicable)*
- Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or*

CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be

*electronic) [Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.11.15 – Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an effective date of enrollment determination. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)*

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §*
- (Ex: Medicare Program Integrity Manual chapter 15.XX)*

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)*
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)*

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial Medicare enrollment application. On [Month] [DD], [YYYY], [MAC Name] sent a development request to John Smith for additional documentation/information to continue processing his enrollment application. However, John Smith did not submit the requested documentation within 30 days. As a result, [MAC Name] properly rejected John Smith's Medicare enrollment application received on [Month] [DD] [YYYY]. On [Month] [DD] [YYYY], John Smith submitted another Medicare enrollment application, which was processed and subsequently approved with an effective date of [Month] [DD], [YYYY] in accordance with 42 C.F.R. § 424.520.

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of your effective date of participation in the Medicare program. As a result, the effective date of participation will remain the same.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the "Register New Account" form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law**

- with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;*
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name*
- Your Medicare PTAN (if applicable)*
- Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.16 – Unfavorable Reconsideration Request Model Letter for Revocation Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-21)
- 42 C.F.R. § 424.535(a)(revocation reason 1-21)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has denied or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1-21).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe’s medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that the suspension of her medical license was rescinded. In addition, [MAC Name] has confirmed that Jane Doe’s medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe’s Medicare enrollment application under 42 C.F.R. § 424.535(a)(1).)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the implementation of a revocation. As a result, the revocation of your Medicare billing privileges is upheld.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

- 1. Clicking Register on the DAB E-File home page;*
- 2. Entering the information requested on the “Register New Account” form; and*
- 3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
 - Specifies the basis for contending that the findings and conclusions are incorrect;**
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name*
- Your Medicare PTAN (if applicable)*
- Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be*

deemed to have consented to electronic service.

- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

*[MAC Appeal Receipt Address]
[Call Center Telephone Number]*

Sincerely,

*[Signature of Hearing Officer] (May be
electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]*

15.24.11.17 – Reconsideration Further Information Required for Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: *[Email address provided by the person who submitted the Reconsideration.]*

Subject: *Medicare Provider Enrollment Reconsideration re: [Provider/Supplier Name]*

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

*Attn: [Signer/Submitter of Reconsideration] (If submitted on behalf of an organization or group)
[Address] (Address from which the Reconsideration was sent)
[City], [State] [Zip Code]*

Re: Reconsideration Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the Reconsideration]:

On [Month] [DD], [YYYY], [MAC Name] issued a reconsideration decision. As stated in the [Month] [DD], [YYYY] reconsideration decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC Reconsideration Receipt Address]

[MAC Reconsideration Receipt Email Address]

[MAC Reconsideration Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.25 – Review Procedures for Determinations that Affect Participation in the Medicare Program

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Background

This review process of initial determinations applies to all providers and suppliers and ensures that all current and prospective providers and suppliers 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 Administrative Law Judge (ALJ) review of a reconsideration decision within the Civil Remedies Division of the Departmental Appeals Board (CRD DAB). Providers and suppliers may thereafter seek review of the ALJ decision in the Appellate Division of the Departmental Appeals Board (DAB) and may then request judicial review in Federal District Court.

For purposes of this chapter, in accordance with 42 C.F.R. § 498.3, an initial determination includes: (1) the denial of enrollment in the Medicare program; (2) the revocation of a provider's or supplier's Medicare billing privileges; and (3) the effective date of participation in the Medicare program.

Any corrective action plan (CAP) or reconsideration request that purports to challenge an enrollment action other than the initial determinations identified above (including inclusion on the CMS Preclusion List and Opt-Out Status) shall be forwarded to CMS at

ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The Medicare Administrative Contractor (MAC) shall take no action on the provider's or supplier's information on its enrollment record regarding an appeal submission for revocations forwarded to CMS for processing unless otherwise instructed by the Provider Enrollment and Oversight Group (PEOG).

A provider or supplier dissatisfied with the initial determinations referenced above, may challenge the determination. All properly submitted requests shall be reviewed at the enrollment level. As a result, if one letter attempts to challenge the initial determination for a group enrollment in addition to individual practitioner enrollment(s), each enrollment shall receive a separate decision. All submissions shall be processed in the order in which they are received. All CAPs and/or reconsideration requests will be reviewed by an individual separate and apart from the individual involved in the implementation of the initial determination.

Depending on the regulatory authority under which an initial determination is issued, providers and suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance with all applicable Medicare requirements by correcting the deficiencies (if possible) that led to the initial determination, specifically either the denial of enrollment into the Medicare program under 42 C.F.R. § 424.530(a)(1) or the revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). While CAPs may only be submitted in response to a denial under 42 C.F.R. § 424.530(a)(1) or a revocation under 42 C.F.R. § 424.535(a)(1), all initial determinations allow for the submission of a reconsideration request. A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

Any CAPs and/or reconsideration requests received in response to initial determinations involving the following, either in whole or in part, shall be forwarded to CMS for review within 10 business days of the date of receipt. The CAP and/or reconsideration request shall be sent to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.

- *All CAPs and reconsideration requests for certified providers/suppliers (as defined in MPIM, Ch. 15, 15.4);*
- *CAPs and reconsideration requests for Independent Diagnostic Testing Facilities;*
- *CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPP);*
- *CAPs and reconsideration requests for Opioid Therapy Programs (OTPs);*
- *Reconsideration requests for enrollment denials pursuant, in whole or in part, to 42 C.F.R. § 424.530(a)(2), (3), (6), (11), (12), (13), and (14);*
- *Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), and (21);*
- *Requests for reversals of denials pursuant to 42 C.F.R. § 424.530(c) and/or revocations pursuant to 42 C.F.R. § 424.535(e);*
- *Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);*
- *Reconsideration requests challenging the addition of years to an existing re-enrollment bar;*
- *Reconsideration requests challenging whether an individual or entity other than the provider or supplier that is the subject of the second revocation was the actual subject of the first revocation;*
- *Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in § 422.2 or § 423.100; and*
- *Reconsideration requests regarding opt-out status.*

If the provider or supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), (5) or (9), in conjunction with any denial or revocation reason(s) listed above, those CAPs and/or reconsideration requests should also be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt and the determination will be rendered by CMS. If the provider or supplier only submits a CAP for the noncompliance portion of any initial determinations listed above, the CAP must be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt, even if the provider or supplier does not submit a reconsideration request. The MAC shall not process the CAP if it is required to be forwarded to CMS. If the provider or supplier later submits a reconsideration request, the reconsideration request must also be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt.

All CAPs and reconsideration requests received by the MACs that are not specifically identified above as being required to be forwarded to CMS for review, shall be processed and a decision rendered by the MACs. However, CMS may exercise its discretion to review any CAP and/or reconsideration request and issue a decision regardless of the basis for the initial determination.

(NOTE: This includes all CAPs and reconsideration requests for DMEPOS suppliers that fit the criteria identified above. In addition, as also indicated above, CAPs may only be submitted for denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocations pursuant to 42 C.F.R. § 424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), or (21), the submission should still be forwarded to CMS within 10 business days of the date of receipt to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.)

PEOG shall notify the MAC via email when it receives a CAP and/or reconsideration request for a provider or supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider or supplier's information on its enrollment record if there is a CAP and/or reconsideration request pending for a revocation action unless otherwise instructed by PEOG. The MAC shall email ProviderEnrollmentAppeals@cms.hhs.gov with any inquiries, questions, or requests.

All documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) shall be saved in PDF format. The date on the CAP and reconsideration request decisions should be the same date as the date the decision is issued to the provider/supplier/representative.

B. Reopening and Revising CAP and Reconsideration Determinations

Once a CAP and/or reconsideration decision is issued, the MAC shall not reopen and revise a CAP and/or reconsideration decision without PEOG's prior approval, even if the MAC rendered the CAP or reconsideration decision independently. The MAC shall send all requests to reopen and revise a CAP and/or reconsideration decision to ProviderEnrollmentAppeals@cms.hhs.gov and await further instruction before taking any action regarding the CAP and/or reconsideration decision.

C. Requests to the MACs

The MAC shall work with and provide PEOG and the Office of General Counsel (OGC), when applicable, all necessary documentation related to any and all CAPs, reconsideration requests, ALJ appeals, DAB appeals, or requests for judicial review.

The following are examples of information the MAC may be asked to provide. This is not an exhaustive list.

- *A copy of the initial determination letter;*
- *A chronological timeline outlining: (1) the processing of applications; (2) the date they began providing services at the newest assigned location; and (3) if there were development requests;*
- *The hearing officer's decision as well as the provider or supplier's CAP and/or reconsideration request;*
- *A complete copy of all application Form CMS-855s, and any supporting documentation submitted with the provider or supplier's application;*
- *All background information and investigative data the hearing officer used to make their decision. Including any on-site visit reports; the MAC's recommendation for administrative action based on the on-site visit;*
- *Contact information for the person(s) who signed both the revocation and reconsideration decision letters.*

The MAC shall supply PEOG or OGC with all requested documentation within 5 business days of receipt of the request, unless requested sooner.

All requested documentation shall be provided in PDF format (if possible) and saved with a file name that identifies the content of the document.

If a CAP and/or reconsideration decision requires the MAC to take action on a provider's or supplier's enrollment, such as reinstating the provider's or supplier's enrollment to an active status, the MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date the CAP and/or reconsideration decision is issued unless additional documentation is needed to update the enrollment. If a CAP or reconsideration decision requires the provider or supplier to submit further information before the enrollment can be updated, such as an enrollment application, the MAC shall allow 30 calendar days for the provider or supplier to submit the necessary information. The MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date of receipt of the additional information/documentation. If the provider or supplier does not submit the necessary information within 30 calendar days, the MAC shall contact PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov for further instruction.

D. Timing of CAP and Reconsideration Request Submissions

A provider or supplier who wishes to submit a CAP must file its request in writing within 35 calendar days of the date of the initial determination. A provider or supplier who wishes to submit a reconsideration request must file its request in writing within 65 calendar days of the date of the initial determination. The date on which CMS or the MAC receives the submission is considered to be the date of filing. See section D below for information on calculating timely submissions.

The mailing and email address for all CAPs and reconsideration requests to be rendered by CMS identified in section 15.25(A) is:

*Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850*

ProviderEnrollmentAppeals@cms.hhs.gov

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review, and may result in the dismissal of any untimely submitted reconsideration request. 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 circumstances outside of the provider's or supplier's control such as 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.*

If a reconsideration request is not timely filed, as required in 42 C.F.R. § 498.22, CMS will make a determination as to whether good cause exists. If a MAC receives an untimely CAP and/or reconsideration request that it believes is entitled to a good cause exception related to untimeliness, the hearing officer must request approval from PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov with an explanation as to why good cause is believed to exist before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. The MAC shall not take action on the CAP and/or reconsideration request until it receives a response from CMS regarding the good cause exception request.

E. Time Calculations

Per 42 C.F.R. § 498.22(b)(3), the date of receipt of an initial determination is presumed to be 5 calendar days after the date on the initial determination notice unless there is a showing that it was, in fact, received earlier or later.

A CAP must be received by the MAC or CMS within 35 calendar days of the date of the initial determination. A reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. If the 35th day (for a CAP) or 65th day (for a reconsideration request), falls on a weekend, or Federally recognized holiday, the CAP and/or reconsideration request shall be considered timely filed if received on the next business day. In the case of an email submission of a CAP and/or reconsideration request, the filing date is presumed to be the date of receipt of the email. Consider the following example:

An initial determination letter is dated April 1. The provider is presumed to have received the initial determination on April 6. The provider submits a CAP and/or reconsideration request by mail that is received on June 10, 65 calendar days after April 6. This is considered timely because it is presumed that the provider did not receive the initial determination letter until April 6.

It is the provider or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider or supplier's enrollment information, including its correspondence address. Failure to timely update a correspondence address or other address included in the enrollment record does not constitute an "in fact" showing that an initial determination letter was received after the presumed date of receipt.

F. Signatures

A CAP and/or reconsideration request must be submitted in the form of a letter that is signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative, as defined in 42 C.F.R. § 498.10. If the representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic.

Authorized or delegated officials for groups cannot sign and submit a CAP and/or reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

(NOTE: The provider or supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "representative" for purposes of signing a reconsideration request without the requisite appointment statement and signature by the individual provider or supplier.)

If the CAP and/or reconsideration request is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the MAC shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the CAP and/or reconsideration request. The MAC shall allow 15 calendar days from the date of the development request letter for the CAP and/or reconsideration request submitter to respond to the development request.

If the CAP and/or reconsideration request submission is not appropriately signed and no response is timely received to the development request (if applicable), the MAC shall dismiss the CAP and/or reconsideration request using the applicable model dismissal letter.

G. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider or supplier may appoint as its representative any individual that is not disqualified or suspended from acting as a representative in proceedings before the Secretary of the Department of Health and Human Services or otherwise prohibited by law to engage in the appeals process. If this individual is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with CMS or the MAC. Once a representative has been properly appointed, the representative may sign and/or submit a CAP, reconsideration request, request for reversal, or a request for good cause exception on behalf of the provider or supplier.

H. Submission of Enrollment Application while a CAP and/or Reconsideration Request is Pending/Submission Timeframe has not Expired

If a provider or supplier's enrollment application is denied, the provider or supplier must wait until the time period in which to submit a CAP and/or reconsideration request has ended before submitting a new enrollment application, change of information, or provides any additional information to update their enrollment record. If the MAC receives an enrollment application, change of information, or additional information to update a provider's or supplier's enrollment record prior to the conclusion of the time period in which to submit a CAP and/or reconsideration request, the MAC shall return the application unless the application is received as part of the provider's or supplier's CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider or supplier that currently has a

pending CAP and/or reconsideration request for revocations or is still within the submission time period for denials unless instructed by CMS to do so. Any applications received while the provider or supplier is in a revoked status should be returned to the provider or supplier and not processed pursuant to 15.8.1.

15.25.1 – Corrective Action Plans (CAPs)

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Background

A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance by correcting the deficiencies (if possible) that led to the initial determination. CAPs may only be submitted in response to enrollment denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

B. Requirements for CAP Submission

CAP submission:

- (1) Must contain, at a minimum, verifiable evidence that the provider or supplier is in compliance with all applicable Medicare requirements;*
- (2) Must be received within 35 calendar days from the date of the initial determination (see section 15.25(D) for clarification on timing). The contractor shall accept a CAP via hard-copy mail, email, and/or fax;*
- (3) Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;*
- (4) Should include all documentation and information the provider or supplier would like to be considered in reviewing the CAP.*
- (5) For denials, the denial must be based on 42 C.F.R. § 424.530(a)(1);*
 - a. For denials based on multiple grounds of which one is § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter (If multiple grounds are involved of which one is § 424.530(a)(1), the MAC shall:
 - i. Only consider the portion of the CAP pertaining to § 424.530(a)(1). The other denial bases may only be reviewed as a reconsideration.**
- (6) For revocations, the revocation must be based on 42 C.F.R. § 424.535(a)(1);*
 - a. Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted.*
 - i. For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to 424.535(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall*

address this in the acknowledgment email or letter sent to the provider or supplier using the model acknowledgment letter. (If multiple grounds are involved of which one is § 424.535(a)(1), the MAC shall:

- 1. Only consider the portion of the CAP pertaining to § 424.535(a)(1). The other revocation bases may only be reviewed as a reconsideration.*

C. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider or supplier, the MAC shall use the model acknowledgment letter to email (if a valid email address is available) and send a hard-copy letter to the address included on the CAP submission letter or if no address is listed on the CAP submission letter, then the return address on the envelope from which the CAP was submitted within 14 calendar days of the date of receipt of the CAP, informing the provider, supplier, or its representative that a CAP decision will be rendered within 60 calendar days of the date of receipt of the CAP. If no address is listed in the CAP, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record.

*If the provider's or supplier's CAP cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative), or any other reason, the MAC shall **not** send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter.*

D. Dismissing a CAP

A CAP shall be dismissed when the provider or supplier does not have the right to submit a CAP for the initial determination, or when the provider or supplier submitted the CAP improperly or untimely (see 15.25.1(B)). As a result, the CAP shall not be reviewed. The MAC shall use the model dismissal letter when dismissing a CAP. All unacceptable CAPs shall be dismissed as soon as possible.

If a provider or supplier concurrently submits a CAP and reconsideration request, but the initial determination being appealed does not afford CAP rights or the CAP submission is untimely, the MAC shall dismiss the CAP using the No CAP Rights Dismissal Model Letter or Untimely CAP Dismissal Model Letter and review the reconsideration request in accordance with the instruction in 15.25.2.

E. CAP Analysis

The MAC shall only review the CAP as it relates to denial of enrollment pursuant to 42 C.F.R. § 424.530(a)(1) or a revocation of billing privileges pursuant to § 424.535(a)(1). The MAC must determine whether or not the information and documentation submitted with the CAP establishes that the provider or supplier has demonstrated compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination. If the MAC finds that the CAP corrects the deficiency that led to the initial determination, then the MAC shall overturn the initial determination as it relates to the denial reasons under 42 C.F.R. § 424.530(a)(1) or revocation under 42 C.F.R. § 424.535(a)(1). If the denial of enrollment is overturned completely, the MAC shall continue processing the previously denied enrollment application in accordance with standard processing procedures. If the revocation is overturned completely, the MAC shall reinstate the provider's or supplier's enrollment to an approved status based on the date the provider or supplier came into compliance. Consider the following example:

Example 1: A provider or supplier is denied enrollment under 42 C.F.R. § 424.530(a)(1) or revoked under 42 C.F.R. § 424.535(a)(1) because its required license has been suspended. The provider timely submits a CAP in which it provides evidence that its licensure has been reinstated and is currently active. After confirming the status of current licensure, the MAC should render a favorable CAP decision because the provider or supplier has corrected the licensure issue that led to enrollment denial or revocation.

If the provider or supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include in the decision letter that the CAP was reviewed only in regards to the 42 C.F.R. § 424.535(a)(1) basis.

If the provider or supplier does not submit information that establishes compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination, the MAC need not contact the provider or supplier for the missing information or documentation. The MAC shall instead deny the CAP. Under 42 C.F.R. § 405.809(a)(2), with respect to the revocation basis, the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.

F. Processing and Approval of CAPs

The time to submit a reconsideration request continues to run even though the MAC has received a CAP and is reviewing the CAP. Therefore, the time period in which to submit a reconsideration request does not stop once a CAP is received and while the CAP is being reviewed. The provider or supplier must submit a reconsideration request within 65 days of the date of the initial determination, even if a CAP is timely submitted and accepted.

The hearing officer shall issue a written decision within 60 calendar days of the date of receipt of the accepted CAP. The hearing officer shall email and mail a hard copy of the CAP decision to the provider or supplier or the individual that submitted the CAP, unless an email address is unavailable or the email is returned, then only a hard copy letter shall be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also send the CAP decision letter via fax if a valid fax number is available.

If the MAC approves a CAP, it shall notify the provider or supplier by issuing a favorable decision letter following the applicable model CAP letter. The MAC shall continue processing the enrollment application under standard processing timelines or restore billing privileges (as applicable) within 10 business days of the date of the CAP decision or the date of receipt of additional documentation, if needed.

For denials – and unless stated otherwise in another CMS directive or instruction – the effective date is the later of either the date of the filing of the enrollment application or the date on which services were first rendered. Consider the following examples:

- 1. Denials - A physician's initial enrollment application is denied on March 1, 2018. The physician submits a CAP showing that, as of March 20th, the physician was in compliance with all Medicare requirements. If the MAC or CMS approves the CAP, the effective date of for the physician's Medicare billing privileges should be March 20th, as that is the day on which the physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with all Medicare requirements until March 20.*

2. *Revocations – A physician’s medical license is suspended on June 1st. The physician’s Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June 15th. The physician then submits a CAP showing that, as of July 1st, the physician is currently licensed. If the MAC or CMS approves the CAP, the effective date for reactivation of the physician’s Medicare billing privileges should be July 1st as that is the day on which physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision does not be apply in this situation.*

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any CAP decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their CAP decision letter. The MAC shall not reinstate the provider’s or supplier’s enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the CAP decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

G. Withdrawal of CAP

The provider, supplier, or the individual who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. The withdrawal of the CAP must be postmarked prior to the CAP determination date. The request to withdraw the CAP must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a CAP, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the CAP and advising that the request has been dismissed, utilizing the applicable model letter.

H. Concurrent Submission of CAP and Reconsideration Request

If a provider or supplier submits a CAP and a reconsideration request concurrently in response to any denial of enrollment under 42 C.F.R. § 424.530(a)(1) or any revocation of billing privileges under 42 C.F.R. § 424.535(a)(1), the MAC shall first process and make a determination regarding the CAP, only as it relates to the denial and/or revocation under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1). If the MAC renders a favorable decision as it relates to 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), the MAC shall only render a reconsideration decision on the remaining authorities not addressed by the favorable CAP decision. Processing timelines still apply.

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the MAC shall coordinate the review of the CAP and reconsideration request to ensure that the CAP is reviewed and a decision rendered before a reconsideration decision is rendered (if the initial determination is not resolved in its entirety by the CAP decision).

If the CAP is approved and resolves the basis for the initial determination in its entirety, the model CAP decision letter shall be sent to the provider or supplier with a statement that the reconsideration request will not be evaluated because the initial determination has been overturned. If the CAP decision does not fully resolve the initial determination or results in a gap in the provider’s or supplier’s billing privileges, the MAC shall also process the reconsideration request.

If the CAP is denied:

- *There are no further appeal rights; therefore, the CAP decision cannot be appealed. As a result, do not include further appeal rights for a CAP only decision.*
- *The MAC shall notify the provider or supplier of the denial of the CAP via the applicable CAP model letter.*
- *The provider or supplier may continue with the appeals process if it has filed a reconsideration request or is preparing to submit such a request and has not exceeded the timeframe in which to do so.*
- *The reconsideration request, if properly submitted, shall be processed.*

15.25.2 – Reconsideration Requests

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Background

A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

B. Requirements for Reconsideration Request Submission

- 1) *Must contain, at a minimum, state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement;*
- 2) *Must be received within 65 calendar days from the date of the initial determination (see section 15.25(D) for clarification on timing). The contractor shall accept a reconsideration request via hard-copy mail, email, and/or fax;*
- 3) *Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;*
- 4) *Should include all documentation and information the provider or supplier would like to be considered in reviewing the reconsideration request;*

C. Receipt Acknowledgement of Reconsideration Request

Upon receipt of a properly submitted reconsideration request, the MAC shall send an email (if a valid email address is available) and hard-copy letter, to the individual that submitted the reconsideration request to acknowledge receipt of the reconsideration request using the applicable model acknowledgment letter within 14 calendar days of the date of receipt of the reconsideration request. The MAC shall send a hard-copy letter to the address listed in the reconsideration request submission or the return address listed on the reconsideration request submission envelope if no address is included on the reconsideration request letter. If no address is listed in the reconsideration request or on the envelope, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record. In the acknowledgment letter/email (if applicable), the MAC shall advise the requesting party that the reconsideration request will be reviewed and a determination will be issued within 90 calendar days from the date of receipt of the reconsideration request. The MAC shall include a copy of the acknowledgment letter and email (if applicable) in the reconsideration file. If the

reconsideration should have been submitted to CMS, the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall forward the appeal to CMS within 10 business days of the date of receipt of the reconsideration request (as specified in 15.25(A)).

*If the provider's or supplier's reconsideration request cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative, or any other reason), the MAC shall **not** send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter.*

D. Reconsideration Determination

The MAC shall review all documentation in the record relevant to the initial determination and issue a written determination within 90 calendar days of the date of receipt of the accepted reconsideration request.

A proper reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. Refer to section 15.25(D) for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider or supplier, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the reconsideration decision being issued. The hearing officer must determine whether an error was made in the initial determination at the time the initial determination was implemented, based on all of the evidence presented. This includes:

- The initial determination itself,*
- The findings on which the initial determination was based,*
- The evidence considered in making the initial determination, and*
- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.*

If the appealing party has additional information that it would like the hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an ALJ specifically allows the party to do so under 42 C.F.R. § 498.56(e).

E. Issuance of Reconsideration Determination

The hearing officer shall issue a written decision within 90 calendar days of the date of receipt of the accepted reconsideration request. The hearing officer shall email and mail a hard copy of the reconsideration decision to the provider or supplier or the individual that submitted the reconsideration request, unless an email address is unavailable or the email is returned, then only a hard copy letter should be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the CAP decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter and include:

- The regulatory basis to support each reason for the initial determination;*

- *A summary of the documentation that the provider or supplier provided, as well as any additional documentation reviewed as part of the reconsideration process;*
- *The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;*
- *A clear explanation of why the hearing officer is upholding or overturning the initial determination in sufficient detail for the provider or supplier to understand the hearing officer's decision and, if applicable, the nature of the provider's or supplier's deficiencies. This explanation should reference the specific regulations and/or sub-regulations supporting the decision, as well as any documentation reviewed;*
- *If applicable, an explanation of how the provider or supplier does not meet the Medicare enrollment criteria or requirements;*
- *Further appeal rights, regardless of whether the decision is favorable or unfavorable, procedures for requesting an ALJ hearing, and the addresses to which the written appeal must be mailed or e-mailed. Further appeal rights shall only be provided for reconsideration decisions. There are no further appeals rights related to CAP decisions; and*
- *Information the provider or supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); NPI; and a copy of the reconsideration decision).*

Example 1: If a provider or supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall review the initial determination, the enrollment application preceding the site visit, the site investigation report(s), the reconsideration request and supporting documentation, as well as any other relevant information, to determine if an error was made in the implementation of the initial determination (e.g., if an error was made during the site visit, or the site visit was conducted at the wrong location.) If the MAC finds that an error was made during the site visit, which found the provider or supplier to be non-operational, the MAC shall order an additional site visit. If an additional site visit is ordered, the MAC shall await the findings of the site investigator, via the site visit report, before issuing a reconsideration decision. If the site visit report finds the provider or supplier to be operational then the MAC shall overturn the revocation of the provider's or supplier's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(5) using the applicable model letter.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's billing privileges to an approved status as of the effective date determined in the reconsidered determination or continue processing the enrollment application (as applicable). Unless otherwise instructed by PEOG, the MAC shall only send the favorable reconsideration decision to the provider or supplier, authorized or delegated official, or its representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider or supplier of the enrollment action being taken. All enrollment updates shall be completed within 10 business days of the date the reconsideration decision was issued or the date of receipt of additional documentation, if needed.

For initial enrollments, the effective date of Medicare billing privileges is based on the date the provider or supplier is found to be in compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable retrospective billing provisions. (See section 15.17 of this chapter for more information.) The MAC shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and

Ownership System (PECOS). For DMEPOS suppliers, the effective date is the date awarded by the NSC.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any reconsideration decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their reconsideration decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the reconsideration decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

F. Withdrawal of Reconsideration Request

The provider, 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 of a reconsideration request must be postmarked prior to the reconsideration decision date. The request to withdraw the reconsideration request must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a reconsideration request, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the reconsideration request and advising that the request has been dismissed, utilizing the applicable model letter.

G. Requests for Reversal under 42 C.F.R. § 424.530(c)/424.535(e)

Under 42 C.F.R. § 424.530(c)/424.535(e), a provider or supplier may request reversal of a denial of enrollment or revocation of billing privileges if the denial or revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services. The revocation may be reversed, at the discretion of CMS, if the provider or supplier terminates and submits proof that it has terminated its business relationship with the individual against whom the adverse action is imposed within 30 days of the initial determination. Information that may provide sufficient proof includes, but is not limited to, state corporate filings, IRS documentation, sales contracts, termination letters, evidence of unemployment benefits, board governance documents, and payroll records.

If the MAC receives a CAP and/or reconsideration request from a provider or supplier to reverse or rescind a denial or enrollment or revocation due to the termination of the business relationship between the provider or supplier and the individual against whom the adverse action is imposed, the MAC shall not take any action. The MAC shall forward the CAP and/or reconsideration request to ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of receipt. The MAC shall not take any action pursuant to the request until further instruction is provided by CMS.

H. Not Actionable CAPs and Reconsideration Requests

If the issue in the initial determination is resolved prior to a CAP and/or reconsideration decision being rendered, the basis of the initial determination may become moot and the CAP

and/or reconsideration request will be not actionable. The MAC will be notified if an action has been taken that would render a CAP and/or reconsideration request not actionable as CMS would contact the MAC to rescind the revocation or reinstate the provider or supplier's Medicare billing privileges. If the MAC receives such a notification, then the MAC shall review to determine if a CAP and/or reconsideration request has become not actionable. If so, the MAC shall send a hard copy letter should be mailed to the return address on the CAP or reconsideration request, as well as the provider's or supplier's correspondence address using the applicable not actionable model letter. The MAC shall also send an email if a valid email address is available. The MAC may also send via fax if a valid fax number is available. The MAC shall attach a copy of the letter informing the provider or supplier of the enrollment action which led to the CAP and/or reconsideration request becoming not actionable. If there is a scenario not captured in the not actionable model letter and the MAC believes a CAP and/or reconsideration request has become not actionable, the MAC should email ProviderEnrollmentAppeals@cms.hhs.gov for guidance.

I. Requesting Guidance Related to CAPs and Reconsideration Requests

If the MAC encounters a situation that is not addressed by these instructions, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action.

15.25.3 – Further Appeal Rights for Reconsidered Determinations (Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Administrative Law Judge (ALJ) Hearing

The CMS or a provider or supplier dissatisfied with a reconsidered determination is entitled to review by an ALJ with the CRD DAB. 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. To request final ALJ review, the provider or supplier must file an appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, the provider or supplier must first register a new account by:

- (1) Clicking Register on the DAB E-File home page;*
- (2) Entering the information requested on the “Register New Account” form; and*
- (3) Clicking Register Account at the bottom of the form. If the provider or supplier has more than one representative, each representative must register separately to use DAB E-File on his/her/its behalf.*

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, a provider or supplier may file an appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and*

- *Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.*

All documents must be submitted in PDF form. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Pursuant to 42 C.F.R. § 405.809(a)(2), a provider or supplier may not appeal an adverse determination for a CAP, if one was made.

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 CRD DAB will issue a letter by certified mail to the supplier, CMS and the 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 MAC 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. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider’s billing privileges). This may result in PEOG providing specific instructions to the contractor to modify model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns and/or modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider or supplier of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the settlement or ALJ decision no later than 10 business days from the date it received PEOG’s specific instructions.

B. Departmental Appeals Board (DAB) Hearing

CMS or a provider/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.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the MAC of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the DAB decision no later than 10 business days from the date it received PEOG's specific instructions.

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.

15.25.4 - External Reporting Requirements for CAPs and Reconsideration Requests

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Monthly

Using the provider enrollment appeals reporting template, the MAC shall complete all columns listed for all appeal submissions (CAPs and reconsideration requests). No column should be left blank.

The response in column A labelled, "Initial Determination Type," should be one of the following:

- **Denial:** CAP or Reconsideration Request that challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(11).
- **Revocation:** CAP or Reconsideration Request that challenges the revocation of Medicare billing privileges or provider/supplier number pursuant to 42 C.F.R. § 424.535(a)(1)-(14).
- **Effective Date:** Reconsideration request that challenges an initial determination that establishes an effective date of participation in the Medicare program, including the effective date of reactivation after deactivation.

The response in Column H labelled, "Final Decision Result," should be one of the following:

1. **Not Actionable:** Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Fingerprints have received a passed designation, initial determination has been reopened and revised).
2. **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status, the effective date modified, or application processing has continued.
3. **Unfavorable (to provider/supplier):** MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining

the same.

- 4. **Dismissed:** The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)*
- 5. **Rescinded:** MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.*
- 6. **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).*

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall cover the prior month's appeal submissions (e.g., the February report shall cover all January CAPs/reconsideration requests). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

15.27.4 - External Reporting Requirements

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Monthly

Using the existing template, the MAC shall capture the following information for all denied Form CMS-855 and Form CMS-20134 paper and web applications (to include those entered in PECOS and those not entered in PECOS). Denials from Form CMS-20134 shall be listed separately:

- LBN of the provider/supplier
- NPI
- State
- Contractor ID
- The denial reason (For any applications denied using the 'Other (CMS Only)' reason in PECOS, the MAC shall specify the denial reason in column U)
- If the denial was entered in PECOS (Y/N)

The reports shall be sent to the Provider Enrollment & Operations Group (with a copy to the MAC's Contracting Officer's Representative (COR)) no later than the 15th of each month; the report shall cover the prior month's denials (e.g., the February report shall cover all January denials).

**PLEASE INCLUDE THIS COMPLETED FORM WITH THE SUBMISSION OF
YOUR CORRECTIVE ACTION PLAN AND/OR RECONSIDERATION REQUEST**

Improperly submitted requests may be dismissed



Provider/Supplier Name: _____

Provider/Supplier Address: _____

National Provider Identifier (NPI): _____ **PTAN:** _____

Provider/Supplier Email Address: _____

Provider/Supplier Fax Number: _____

Medicare Administrative Contractor: [Insert MAC Name and Jurisdiction] _____

This appeal submission is based on a(n): **Denial** **Revocation** **Effective Date**

CHOOSE ALL THAT APPLY FROM THE FOLLOWING:

Be sure to indicate if you are submitting both a CAP and Reconsideration Request or either individually

I am submitting a –

Corrective Action Plan (CAP) – *The CAP is an opportunity for the provider/supplier to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges. A CAP may only be submitted for denials under 42 C.F.R. § 424.530(a)(1) or revocation of billing privileges under 42 C.F.R. § 424.535(a)(1).*

When submitting a CAP, it must:

1. Contain verifiable evidence that the provider/supplier is in compliance with Medicare requirements;
2. Be submitted within 35 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 provider/supplier, the authorized or delegated official, or a legal representative.
4. If a legal representative is an attorney, the CAP must also contain a statement that the attorney has the authority to act on behalf of the provider/supplier. If the legal representative is not an attorney, the CAP must contain written notice of the appointment of the non-attorney as legal representative signed by the provider, supplier, or authorized/delegated official.

A decision will be issued within 60 days of receipt of the CAP.

The time to submit a reconsideration request runs concurrently with the time to submit a CAP. For example, if a CAP is submitted 20 days after the initial determination, there are 40 days remaining to submit a reconsideration request. These 40 days continue to elapse while the CAP is under consideration. Please note that failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

Reconsideration Request – *A reconsideration request is an opportunity for a provider/supplier to furnish evidence that demonstrates that there was an error made at the time of the initial determination affecting participation in the Medicare Program.*

When submitting a reconsideration request, it must:

1. State the issues, or the findings of fact with which you disagree, and the reasons for disagreement.
2. Be submitted within 65 days from the date of the initial determination;
3. Be submitted in the form of a letter that is signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.
4. If a legal representative is an attorney, the reconsideration request must also contain a statement that the attorney has the authority to act on behalf of the provider/supplier. If the legal representative is not an attorney, the reconsideration request must contain written notice of the

appointment of the non-attorney as legal representative signed by the provider, supplier, or authorized/delegated official.

A decision will be issued within 90 days of receipt of the reconsideration request.

Please mail, email, or fax this form, the CAP or reconsideration request letter (signed and dated by the valid submitter), the initial determination letter, and all supporting documentation applicable to the appeal to the following address:

[MAC or CMS Address]

or [MAC or CMS Email Address].

or [MAC Fax Number]

Monthly MAC Appeals Reporting Template Definitions

Column A: Initial Determination Type

1. **Denial:** Appeal challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(11).
2. **Revocation:** Appeal challenges the revocation of Medicare billing privileges or supplier number pursuant to 42 C.F.R. § 424.535(a)(1)-(14).
3. **Effective Date:** Appeal challenges an initial determination that establishes an effective date of participation in the Medicare program or challenges a gap in Medicare billing privileges due to deactivation.

Column H: Final Decision Result

1. **Not Actionable:** Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Initial determination has been reopened and revised).
2. **Favorable(to provider/supplier):** MAC determined an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status or the effective date modified.
3. **Dismissed:** The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, etc.)
4. **Unfavorable(to provider/supplier):** MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining the same.
5. **Rescinded:** MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.
6. **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).

| Initial Determination Type | Provider/Supplier Name (As it appears in PECOS) | NPI | MAC (Including jurisdiction) | Regulatory Authority (As identified on initial determination) | DME Supplier/IDTF Standards (If Applicable) | CAP or Reconsideration Request | Final Decision Result | Date Final Decision is Issued |
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