CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 747	**Date: October 3, 2017**
	Change Request 9924

Transmittal 734, dated July 28, 2017, is being rescinded and replaced by Transmittal 747 dated October 3, 2017-, to update the manual instruction in Chapter 15, Section 15.27.4.A of Pub. 100-08 to remove two references that are no longer applicable due to the revised reporting template. All other information remains the same.

SUBJECT: Update to Reporting Requirements

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to revise the reporting requirements in sections 15.25.1.2 and 15.27.4 in Chapter 15 of Pub. 100-08.

EFFECTIVE DATE: June 27, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 27, 2017

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15/25/15.25.1.2/Reconsideration Requests – Non-certified Providers/Suppliers
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: 747	Date: October 3, 2017	Change Request: 9924

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SUBJECT: Update to Reporting Requirements

EFFECTIVE DATE: June 27, 2017
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IMPLEMENTATION DATE: June 27, 2017

I. GENERAL INFORMATION

A. Background: This CR will update the reporting requirements for appeal cases received by the MACs in order to gain a better understanding of the numbers of cases and types of cases being appealed.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9924.1	The contractor shall report appeal case numbers using the existing template to CMS Provider Enrollment & Oversight Group Division of Compliance and Appeals via email to ProviderEnrollmentAppeals@cms.hhs.gov.		X							NSC
9924.1.1	The contractor shall report appeal case numbers on the 10th of the month following each Fiscal Year (FY) quarter (January 10 for FY Quarter 1, April 10 for FY Quarter 2, July 10 for FY Quarter 3 and October 10 for FY Quarter 4).		X							NSC
9924.2	The contractor shall report total number of appeal cases received.		X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9924.2.1	The contractor shall report the number of appeal cases upheld.		X							NSC
9924.2.2	The contractor shall report the number of appeal cases overturned.		X							NSC
9924.3	The contractor shall report the total number of upheld cases and the total number of overturned cases for all of the categories listed below, using the existing template.		X							NSC
9924.3.1	The contractor shall report the number of enrollment denial appeals received.		X							NSC
9924.3.1.1	The contractor shall report the number of Corrective Action Plans (CAPs) arising out of enrollment denial appeals.		X							NSC
9924.3.1.2	The contractor shall report the number of reconsideration requests arising out of enrollment denial appeals.		X							NSC
9924.3.1.3	The contractor shall report the number of simultaneous submission of CAPs and reconsideration requests arising out of enrollment denial appeals.		X							NSC
9924.3.1.4	The contractor shall report the number of enrollment denial reconsideration requests that were withdrawn.		X							NSC
9924.3.2	The contractor shall report the number of enrollment revocation appeals received.		X							NSC
9924.3.2.1	The contractor shall report the number of CAPs arising out of enrollment revocation appeals.		X							NSC
9924.3.2.2	The contractor shall report the number of enrollment revocation		X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	reconsideration requests received.									
9924.3.2.3	The contractor shall report the number of enrollment revocation reconsideration requests that were withdrawn.		X							NSC
9924.4	This Business Requirement has been deleted.		X							NSC
9924.5	This Business Requirement has been deleted.		X							NSC
9924.6	This Business Requirement has been deleted.		X							NSC
9924.7	The contractor shall include the following on the existing report template: • Number of Simultaneous submission of CAPs and reconsideration requests arising out of enrollment revocation appeals; • Number of effective date appeals (does not apply to the NSC); • Number of fingerprint-related appeals, and; • Number of appeal cases for revocations authorized by CMS.		X							NSC
9924.8	The contractor shall report the number of revocations of Form CMS-855S enrollment applications and list the three most frequent reasons for revocations.									NSC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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): Nigah Mughal, 410-786-0823 or nigah.mughal@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: 1

15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers

(Rev.747, Issued: 10-03-17, Effective: 06-27-17, Implementation: 06-27-17)

NOTE: This section 15.25.1.2 does not apply to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4), §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3). Such reconsiderations are addressed in section 15.25.2.2 below.

A. Timeframe for Submission

A supplier that wishes to request a reconsideration must file its request in writing with the Medicare contractor within 60 days from the supplier's receipt of the notice of denial or revocation to be considered timely filed. Per 42 CFR §498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. A reconsideration request submitted on the 65th day that falls on a weekend or holiday shall still be considered timely filed. The date on which the contractor receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, the reconsideration HO shall make a finding of good cause before taking any other action on the appeal. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

B. Signatures

The reconsideration request must be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

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

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

C. Contractor's Receipt of Reconsideration Request

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

D. Reconsideration Determination

If a timely request for a reconsideration is made, the reconsideration shall be conducted by a HO or senior staff having expertise in provider enrollment and who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination. In other words, separate individuals must conduct/perform/review the denial/revocation, the CAP, and the reconsideration. This is to ensure completely independent reviews of all three transactions.

The HO must hold an on-the-record reconsideration and issue a determination within 90 days of the date of the appeal request.

Consistent with 42 CFR §498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the HO's decision. The HO must determine whether the denial or revocation is warranted 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 a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge 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 administrative law judge specifically allows the party to do so under 42 CFR §498.56(e).

E. Issuance of Reconsideration Decision

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

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;
- A summary of the documentation that the supplier provided;
- A clear explanation of why the HO is upholding or overturning the denial or revocation action in sufficient detail for the supplier to understand the HO's decision and, if applicable, the nature of the supplier's deficiencies;
- If applicable, the regulatory basis to support each reason for the denial or revocation;
- If applicable, an explanation of how the supplier does not meet the enrollment criteria or requirements;
- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the addresses to which the written appeal must be mailed or e-mailed; and
- Information the supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

If the HO overturns the contractor's decision, the contractor shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable "backbilling" restrictions. (See section 15.17 of this chapter for more information.) The contractor shall use

the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System. For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse.

F. Withdrawal of Reconsideration Request

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

15.27.4 - External Reporting Requirements

(Rev. 747, Issued: 10-03-17, Effective: 06-27-17, Implementation: 06-27-17)

A. Quarterly

Using the existing template, the contractor shall furnish to CMS Provider Enrollment & Oversight Group, Division of Compliance and Appeals (PEOG DCA) via e-mail to ProviderEnrollmentAppeals@cms.hhs.gov the following information for the previous quarter:

- Number of revocations of Form CMS-855A enrollments and the three most frequent reasons for said revocations.

- Number of revocations of Form CMS-855B and Form CMS-855I enrollments and the three most frequent reasons therefore. (Form CMS-855B and Form CMS-855I revocations shall be listed separately.)

- Number of revocations of Form CMS-855S enrollments and the three most frequent reasons for said revocations.

- Total number of appeal cases received

- Total number of appeal cases upheld

- Total number of appeal cases overturned

- The number of upheld cases and the number of overturned cases for the following:

    - Number of enrollment denial appeals
    - Number of Corrective Action Plans (CAPs) arising out of enrollment denial appeals
    - Number of reconsideration requests arising out of enrollment denials appeals
        - Include number withdrawn
        - Include reasons for why the decision was made
    - Number of simultaneous submission of Corrective Action Plans (CAPs) and reconsideration requests arising out of enrollment denial appeals
    - Number of enrollment revocation appeals
    - Number of CAPs arising out of enrollment revocation appeals
    - Number of reconsideration requests received arising out of enrollment revocation appeals
        - Include number withdrawn
        - Include reasons for why the decision was made
    - Number of simultaneous submission of CAPs and reconsideration requests arising out of enrollment revocation appeals
    - Number of effective date appeals
    - Number of fingerprint related appeals

    - Number of appeal cases for revocations authorized by CMS

The quarterly reports shall encompass the following time periods:

- October through December
    - Due no later than January 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.
- January through March
    - Due no later than April 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.
- April through June
    - Due no later than July 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.
- July through September
    - Due no later than October 10. If this day falls on a weekend or a holiday, the report must be submitted the following business day.

B. Monthly

Using the existing template, the MAC shall capture the following information for all denied Form CMS-855 paper and web applications (to include those entered in PECOS and those not entered in PECOS):

- 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).

Quarterly Appeals Numbers

MAC NAME:	FISCAL YEAR: 2017				
	Q-1	Q-2	Q-3	Q-4	FY17 TOTAL
TOTAL NUMBER OF REVOCATIONS OF FORM CMS-855A ENROLLMENTS					
List the top three reasons for revocations:					
TOTAL NUMBER OF REVOCATIONS OF FORM CMS-855B ENROLLMENTS					
List the top three reasons for revocations:					
TOTAL NUMBER OF REVOCATIONS OF FORM CMS-855I ENROLLMENTS					
List the top three reasons for revocations:					
TOTAL NUMBER OF REVOCATIONS OF FORM CMS-855S ENROLLMENTS					
List the top three reasons for revocations:					
TOTAL NUMBER OF APPEALS RECEIVED BY MAC (CAPS & RECONSIDERATIONS)					
TOTAL NUMBER OF APPEALS UPHELD					
TOTAL NUMBER OF APPEALS OVERTURNED					
TOTAL NUMBER OF ENROLLMENT DENIAL APPEALS					
The number of providers/supplier enrollment denials that were appealed.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF CAPS ARISING OUT OF ENROLLMENT DENIAL APPEALS					
The number of Corrective Action Plans submitted by providers for appeals regarding enrollment denials.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF RECONSIDERATIONS ARISING OUT OF ENROLLMENT DENIAL APPEALS					
The number of reconsideration requests submitted by providers/suppliers for appeals regarding enrollment denials.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
WITHDRAWN					
Appeal was withdrawn before decision was issued.					
REASONS					
Reasons for why the decision was made.					
TOTAL NUMBER OF SIMULTANEOUS SUBMISSION OF CAPS & RECONSIDERATIONS REQUESTS ARISING OUT OF ENROLLMENT DENIAL APPEALS					
The number of corrective action plans and reconsideration requests submitted simultaneously by providers/suppliers for appeals regarding enrollment denials.					
UPHELD					

Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF ENROLLMENT REVOCATION APPEALS (CAPS & RECONSIDERATIONS)					
The number of first level appeals received arising out of provider/supplier revocations.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF CAPS ARISING OUT OF ENROLLMENT REVOCATIONS					
The number of corrective action plans submitted by providers for appeals regarding revocations.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF RECONSIDERATION REQUESTS ARISING OUT OF ENROLLMENT REVOCATIONS					
The number of reconsideration requests submitted by providers for appeals regarding revocations.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
WITHDRAWN					
Appeal was withdrawn before decision was issued.					
REASONS					
Reasons for why the decision was made.					
TOTAL NUMBER OF SIMULTANEOUS SUBMISSION OF CAPS & RECONSIDERATION REQUESTS ARISING OUT OF ENROLLMENT REVOCATION APPEALS					
The number of corrective action plans and reconsideration requests submitted simultaneously by providers for appeals regarding revocations.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF EFFECTIVE DATE APPEALS					
The number of first level appeals received from providers/suppliers, appealing their effective date.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF FINGERPRINT RELATED APPEALS (CAPS & RECONSIDERATIONS)					
The number of first level appeal requests received for noncompliance with fingerprint requirements for enrollment and revalidations.					
UPHELD					
Decision was favorable to CMS and unfavorable to provider.					
OVERTURNED					
Decision was unfavorable to CMS and favorable to provider.					
TOTAL NUMBER OF APPEAL CASES FOR ENROLLMENT REVOCATIONS AUTHORIZED BY CMS (CAPS & RECONSIDERATIONS)					
The number of first level appeal requests received for revocations initiated by DEA.					