

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-08 Medicare Program Integrity</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 904</b>	<b>Date: September 27, 2019</b>
	<b>Change Request 10978</b>

**SUBJECT: Provider Enrollment Rebuttal Process**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to operationalize the provision under 42 Code of Federal Regulations (C.F.R.) § 424.545(b), which permits providers/suppliers whose Medicare billing are deactivated to file a rebuttal. Specifically, this CR will provide instruction to Medicare Administrative Contractors (MACs) for advising providers/suppliers of their rebuttal rights, as well as for receiving and processing rebuttals.

**EFFECTIVE DATE: December 31, 2019**

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

**IMPLEMENTATION DATE: December 31, 2019**

*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.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	15/Table of Contents
R	15/15.24/15.24.5/15.24.5.4/Model Revalidation Deactivation Letter
R	15/15.24/15.24.5/15.24.5.6/Model Deactivation Letter due to Inactive Provider/Supplier Letter
R	15/15.24/15.24.15/Model Deactivation Letter for an Individual Provider
R	15/15.27/15.27.1/15.27.1.1/Deactivations
N	15/15.27/15.27.5/Rebuttal Process
N	15/15.27/15.27.5/15.27.5.1/Rebuttal Submissions
N	15/15.27/15.27.5/15.27.5.2/Rebuttal Model Letters
N	15/15.27/15.27.5/15.27.5.3/Rebuttal 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: 904	Date: September 27, 2019	Change Request: 10978
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**SUBJECT: Provider Enrollment Rebuttal Process**

**EFFECTIVE DATE: December 31, 2019**

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

**IMPLEMENTATION DATE: December 31, 2019**

## I. GENERAL INFORMATION

**A. Background:** This CR will align provider enrollment policy with the C.F.R. at 42 C.F.R. § 424.545(b), which allows a provider or supplier whose billing privileges have been deactivated to file a rebuttal. The MACs will be responsible for advising providers and suppliers of their right to file a rebuttal in response to any enrollment deactivation. The MACs will also be responsible for receiving, reviewing, and issuing determinations regarding all rebuttals.

**B. Policy:** There are no legislative, statutory, 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								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
10978.1	If no revocation basis exists, the MACs shall deactivate a provider's or supplier's Medicare billing privileges if a basis is found under one of the three regulatory authorities identified in 42 C.F.R. § 424.540(a)(1-3).	X	X	X						NS C
10978.1.1	MACs shall send notification of the deactivation of a provider's or supplier's Medicare billing privileges using the applicable model deactivation letter.	X	X	X						NS C
10978.1.1.1	MACs shall send the notice of deactivation via hard-copy mail and by email, if a valid email address is available. The MAC should also send by fax if a valid fax number is available.	X	X	X						NS C
10978.1.1.1.1	MACs shall save all notifications to providers/suppliers,	X	X	X						NS C

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	authorized/delegated officials, or legal representative in PDF format.									
10978.1.1.1.1	MACs shall mail all notification letters on the same date listed on the notification letter.	X	X	X						NS C
10978.1.1.2	MACs shall ensure that the deactivation letter contains sufficient detail so that it is clear why the provider's or supplier's Medicare billing privileges are being deactivated.	X	X	X						NS C
10978.1.1.3	MACs shall ensure that the deactivation letter includes instruction regarding the provider's or supplier's right to submit a rebuttal in accordance with 42 C.F.R. § 405.374.	X	X	X						NS C
10978.1.1.4	If MACs choose to use a cover sheet, MACs shall use the optional cover sheet provided with this CR.	X	X	X						NS C
10978.1.2	If an application is received for a deactivated provider or supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, MACs shall process the application in accordance with current processing guidelines.	X	X	X						NS C
10978.1.2.1	If a rebuttal determination overturns the deactivation, the MACs shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that have not been processed to completion, unless the application is needed to reactivate the enrollment or if there are new changes being reported.	X	X	X						NS C
10978.1.2.1.1	If a rebuttal determination does not overturn the deactivation in its entirety, the MACs shall continue	X	X	X						NS C

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	processing any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe in accordance with current processing guidelines.									
10978.1.2.2	If an approved reactivation application results in the provider's or supplier's Medicare billing privileges being reactivated without a gap in billing while a rebuttal submission is being reviewed, MACs shall stop processing the rebuttal submission and issue a moot letter using the applicable template.	X	X	X						NS C
10978.1.2.3	MACs shall review all rebuttal submissions received in response to the deactivation of a provider's or supplier's Medicare billing privileges to determine if the rebuttal shall be dismissed or accepted.	X	X	X						NS C
10978.1.2.3.1	MACs shall ensure that the rebuttal submission is received within 20 calendar days from the date of the deactivation letter.	X	X	X						NS C
10978.1.2.3.2	MACs shall ensure that the rebuttal submission specifies the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement.	X	X	X						NS C
10978.1.2.3.3	MACs shall ensure that the rebuttal is signed by the individual provider, supplier, authorized or delegated official, or a legal representative.	X	X	X						NS C
10978.1.2.3.3.1	MACs shall not require an original signature.	X	X	X						NS C
10978.1.2.3.4	If the rebuttal submission is not signed by the individual provider, supplier, authorized or delegated	X	X	X						NS C

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	official, or a legal representative, MACs shall send a development request for an appropriately signed rebuttal submission to be received within 15 calendar days of the date of the development request using the applicable model letter.									
10978.1.2.3.5	If the rebuttal submission is signed by an attorney, the attorney must also state that he/she has the authority to represent the provider/supplier.	X	X	X						NS C
10978.1.2.3.5.1	If the rebuttal submission is signed by an attorney and does not contain a statement that the attorney has the authority to represent the provider/supplier, MACs shall send a development request using the applicable model letter to request the missing statement be received within 15 calendar days of the date of the development request letter.	X	X	X						NS C
10978.1.2.3.5.2	If the rebuttal submission is signed by a legal representative that is not an attorney, the MAC shall require the provider or supplier to sign and submit a written notice authorizing the legal representative to act on his/her/its behalf.	X	X	X						NS C
10978.1.2.3.6	If the rebuttal submission is signed by a legal representative that is not an attorney and does not include a written notice signed by the provider or supplier authorizing the legal representative to act on his/her/its behalf, MACs shall send a development request using the applicable model letter to request the missing written notice signed by the provider or supplier to be received within 15 calendar days of the date of the development request letter.	X	X	X						NS C

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
10978.1.2.3. 7	MACs shall dismiss any rebuttal submission that is not appropriately signed and no development response is received, untimely, does not specify the reasons for disagreement or is a duplicative submission using the applicable model rebuttal dismissal letter.	X	X	X						NS C
10978.1.2.3. 8	MACs shall allow rebuttals to be submitted via hard-copy mail, email, and fax.	X	X	X						NS C
10978.2	MACs shall accept any rebuttal submission for processing that is timely submitted, properly signed, specifies the facts or issued with which the provider or supplier disagrees, the reasons for disagreement and is not a duplicative submission. This includes if the information is timely received from a development request so long as the developed information is sufficient and received within the 15 calendar day timeframe from the date of the development request.	X	X	X						NS C
10978.2.1	MACs shall send a receipt acknowledgement letter within 10 calendar days of the date of receipt of any accepted rebuttal submission using the model rebuttal acknowledgement letter unless the rebuttal determination is issued within 10 calendar days of receipt, then MACs should omit sending the receipt acknowledgement letter and only issue the rebuttal determination.	X	X	X						NS C
10978.2.1.1	MACs shall send a receipt acknowledgement letter via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is	X	X	X						NS C

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	available.									
10978.2.1.1.1	MACs should also send a receipt acknowledgement via fax if a valid fax number is available.	X	X	X						NS C
10978.2.1.2	If the MACs send a good cause exception to CMS for approval, MACs shall begin counting the 10 calendar day requirement for sending a receipt acknowledgement letter on the day the MACs receive CMS approval.	X	X	X						NS C
10978.2.1.2.1	If the MACs do not receive CMS approval, the MACs shall follow the instruction provided in CMS's response to the good cause exception request.	X	X	X						NS C
10978.3	MACs shall process and render a determination for all accepted rebuttal submissions within 30 calendar days of the date of receipt, using the applicable model rebuttal letter.	X	X	X						NS C
10978.3.1	MACs shall limit its review to whether the provider's or supplier's billing privileges were deactivated appropriately.	X	X	X						NS C
10978.3.2	If a development request is issued, the MACs shall use the date of receipt of the developed information/documents for processing standards.	X	X	X						NS C
10978.4	MACs shall send all rebuttal determination letters via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available.	X	X	X						NS C
10978.4.1	MACs should also send rebuttal determination letters via fax if a valid fax number is available.	X	X	X						NS C



Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
10978.4.1.1	MACs shall mail all rebuttal determinations on the date listed on the rebuttal determination.	X	X	X						NS C
10978.5	MACs shall not include further review rights for any rebuttal determination.	X	X	X						NS C
10978.6	MACs shall modify the provider's or supplier's Medicare enrollment record, if necessary, in accordance with the rebuttal determination within 10 business days of the date the rebuttal determination is issued.	X	X	X						NS C
10978.6.1	MACs shall denote in its rebuttal determination letter any additional information/documentation or action required from the provider or supplier prior to making modification(s) to the provider's or supplier's Medicare enrollment record.	X	X	X						NS C
10978.6.2	If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall send the Rebuttal 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/documentation.	X	X	X						NS C
10978.6.2.1	MACs should also contact the provider/supplier via phone if a valid phone number is available regarding the required additional documentation/information.	X	X	X						NS C
10978.6.2.2	If no response is received within 30 calendar days of the second request, the MACs shall contact ProviderEnrollmentAppeals@cms.	X	X	X						NS C

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	hhs.gov within 10 calendar days of not receiving a response to the second request for further instruction.									
10978.7	MACs shall use the provided model letters and follow all instruction included within.	X	X	X						NS C
10978.8	MACs shall record all rebuttal submissions on the rebuttal reporting template.	X	X	X						NS C
10978.8.1	MACs shall complete all columns on the rebuttal reporting template for each rebuttal submission.	X	X	X						NS C
10978.9	MACs shall send a monthly report containing all recorded rebuttal submissions to CMS at ProviderEnrollmentAppeals@cms.hhs.gov, no later than the 15th of each month.	X	X	X						NS C

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			DME MAC	CEDI	
		A	B	HHH			
10978.10	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 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	X	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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 , Joseph Schultz, 410-786-2656 or Joseph.Schultz@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: 2**

# Medicare Program Integrity Manual

## Chapter 15 - Medicare Enrollment

Table of Contents  
*(Rev.904, Issued: 09- 27-19)*

### Transmittals for Chapter 15

15.24.15 – *Model Deactivation Letter*

15.27.5 – *Rebuttal Process*

15.27.5.1 – *Rebuttal Submissions*

15.27.5.2 – *Rebuttal Model Letters*

15.27.5.3 – *Rebuttal Reporting Requirements*

### **15.24.5.4 – Model Revalidation Deactivation Letter**

*(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)*

*(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).*

### **STOPPING BILLING PRIVILEGES**

*[Month] [DD], [YYYY]*

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

*[Address]*

*[City], [State] [Zip Code]*

*Re: Deactivation of Medicare billing privileges*

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

*NPI: [XXXXXXXXXX]*

*PTAN: [XXXXX]*

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

*Dear [Provider/Supplier Name]:*

*Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.*

*Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.*

### ***What record needs revalidating***

*[Name] | NPI [NPI] | PTAN [PTAN]*

*Reassignments:*

*[Legal Business Name] | [dba Name] |*

*<Repeat for other reassignments>*

*CMS lists the records that need revalidating at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.*

### ***REBUTTAL RIGHTS:***

*If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.*

*The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.*

*If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.*

*If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.*

*If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.*

*The rebuttal should be sent to the following:*

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal 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].

### **How to recover your billing privileges**

**Revalidate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

### **If you need help**

Visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name] [Title] [Company]

## **15.24.5.6 – Model Deactivation Letter due to Inactive Provider/Supplier**

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

(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).

### **STOPPING BILLING PRIVILEGES**

[Month] [DD], [YYYY]

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

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

We have stopped your Medicare billing privileges on [deactivation date], due to inactivity. We will not pay any claims after this date.

## What record has been deactivated

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments:

[Legal Business Name] | [dba Name]

<Repeat for other reassignments>

## REBUTTAL RIGHTS:

*If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.*

*The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.*

*If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.*

*If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.*

*If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.*

*The rebuttal should be sent to the following:*

*[MAC Rebuttal Receipt Address]*

*[MAC Rebuttal Receipt Email Address]*

*[MAC Rebuttal Receipt Fax Number]*

## How to recover your billing privileges

**Reactivate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

## If you need help

Visit [go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation)

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

### **15.24.15 – *Model Deactivation Letter***

*(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)*

*(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 Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

#### **DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)[1-2]

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[MAC Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[MAC Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [MAC Name] has not received a Medicare enrollment application reporting this change in ownership.)

#### **REBUTTAL RIGHTS:**

*If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of*



*this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.*

*The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.*

*If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.*

*If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.*

*If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.*

*The rebuttal should be sent to the following:*

*[MAC Rebuttal Receipt Address]*

*[MAC Rebuttal Receipt Email Address]*

*[MAC Rebuttal 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,

[Name] [Title] [Company]

### **15.27.1.1 – Deactivations**

*(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)*

#### **A. Reasons**

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its CMS Provider Enrollment Business Function Lead (PEBFL) - deactivate a provider or supplier's entire enrollment record and Medicare billing privileges when:

- A provider or supplier fails to respond to a revalidation request;
- A provider or supplier fails to respond timely to a revalidation development request, or;
- A provider is enrolled in an approved status without an active reassignment or practice location for 90 days or longer.

The contractor shall not take deactivation actions unless specified in this chapter or other CMS directives. *All deactivation notices shall be mailed on the same date listed on the notification letter.*

#### **B. Regulations**

- Per § 424.540(a)(1), a provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1<sup>st</sup> day of the 1<sup>st</sup> month without a claims submission through the last day of the 12<sup>th</sup> month without a submitted claim;
- Per § 424.540(a)(2), a provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; a provider or supplier fails to report a change in ownership or control within 30 calendar days.
- Per § 424.540(a)(3), a provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

### C. Effective Dates

The effective dates of a deactivation are as follows:

1. Non-Billing §424.540(a)(1) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
2. Failure to Report or Furnish Information §424.540(a)(2) and (3) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
3. The “36-Month Rule” for HHAs – CMS’ provider enrollment staff will determine the effective date during its review of the case.

### D. *Rebuttal Rights*

*A provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal to challenge the deactivation. See 15.27.5 for further instruction.*

### E. Miscellaneous

1. The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).
2. Prior to deactivating an HHA’s billing privileges for any reason (including under the “36-month rule”), the contractor shall refer the matter to its PEBFL for review and approval. The only exception for PEBFL review and approval is deactivations due to failure to comply with a revalidation request.

## **15.27.5 – Rebuttal Process**

***(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)***

### ***A. Background***

*Pursuant to 42 C.F.R. § 424.545(b), a provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374. A rebuttal is an opportunity for the provider or supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per deactivation. Additional rebuttal requests shall be dismissed.*

*If an application is received for a deactivated provider or supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application in accordance with current processing instruction. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless the submitted application is required to reactivate the provider's or supplier's enrollment. If an application, received while a rebuttal submission is pending, is approved prior to the issuance of a rebuttal determination and results in the provider's or supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.*

*Providers and suppliers may submit a rebuttal request for the following deactivation reasons, in accordance with 42 C.F.R. § 424.540(a):*

*(1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.*

*(2) The provider or supplier does not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).*

*(3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.*

## ***B. Notification Letters for Deactivations***

*If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities identified in 42 C.F.R. § 424.540, the contractor shall deactivate the provider's or supplier's Medicare billing privileges unless another CMS direction is applicable. If a revocation authority is applicable, the contractor shall follow the current revocation instruction in 15.27.2, in lieu of deactivating the enrollment. If no revocation authority is applicable, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider's or supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via email if a valid email address is available. The contractor should also send via fax if a valid fax number is available. All notifications shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.*

### ***15.27.5.1 – Rebuttal Submissions***

***(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)***

#### ***A. Requirements and Submission of Rebuttals***

*The rebuttal submission:*

- 1) Must be received by the contractor within 20 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, email, and/or fax;*
- 2) Must specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement;*

- 3) *Should include all documentation and information the provider or supplier would like to be considered in reviewing the deactivation;*
- 4) *Must 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, as defined in 42 C.F.R. § 498.10. If the legal 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 legal 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 and dated by the individual provider or supplier, the authorized or delegated official, or a legal representative.*

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

*If a rebuttal submission is not appropriately signed and no response is received to the development request (if applicable), untimely (as described above), does not specify the facts or issues with which the provider or supplier disagrees and the reasons for disagreement, or is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable model rebuttal dismissal letter. The contractor may make a good cause determination so as to accept any rebuttal that has been submitted beyond the 20 calendar day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider's or supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to [ProviderEnrollmentAppeals@cms.hhs.gov](mailto:ProviderEnrollmentAppeals@cms.hhs.gov) within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.*

### ***B. Time Calculations for Rebuttal Submissions***

*The date of receipt of a deactivation notice is presumed to be 5 days after the date on the deactivation notice unless there is a showing that it was, in fact, received earlier or later.*

*Therefore, the rebuttal must be received within 20 calendar days from the date of the deactivation notice to be considered timely. If the 20<sup>th</sup> calendar day from the date on the deactivation notice falls on a weekend or federally recognized holiday, then the rebuttal shall be accepted as timely if received by the next business day.*

*Consider the following example:*

*A deactivation notice is dated April 8, 2018. The provider or supplier is presumed to have received the deactivation notice on April 13, 2018. The provider or supplier submits a rebuttal that is received on April 28, 2018. The 20<sup>th</sup> calendar day from the date on the deactivation notice is April 28, 2018. However, since April 28, 2018 is a Saturday (weekend day), the rebuttal submission received on April 30, 2018 is considered timely because April 30, 2018 is the next business day following the 20<sup>th</sup> calendar day from the date on the deactivation notice.*

*It is the provider's or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare*

*enrollment record does not constitute an “in fact” showing that the deactivation notice was received after the presumed receipt date (as described above).*

### ***C. Processing Rebuttal Submissions***

*The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar days of receipt of the accepted rebuttal request using the model rebuttal acknowledgment letter, including a rebuttal tracking number. The acknowledgement letter shall also be sent via email, if a valid email address is available. It is optional for the contractor to send the acknowledgement letter via fax, if a valid fax number is available.*

*The contractor shall process all accepted rebuttal submissions within 30 calendar days of the date of receipt. If while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued.*

*The contractor’s review shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider or supplier shall be considered by the contractor in their review.*

- 1) For deactivations under 42 C. F. R. § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the twelve month period preceding the date of deactivation, starting with the 1st day of the 1st month twelve months prior to the date of deactivation. If it is confirmed that billing occurred within twelve months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the twelve month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination.*

*Consider the following example:*

*Dr. Awesome has been enrolled in the Medicare program since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2016. Dr. Awesome’s enrollment is deactivated effective January 1, 2018. Dr. Awesome timely submits a rebuttal statement regarding the deactivation. Upon the contractor’s review of the submitted documentation and internal records, it is confirmed that Dr. Awesome had not submitted claims since January 2016. Therefore, an unfavorable determination would be appropriate in this scenario, as the deactivation was justified.*

- 2) For deactivations under 42 C. F. R. § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within 90 calendar days of when the change occurred. If information was submitted properly and timely, the contractor shall approve the rebuttal request and reinstate the provider’s or supplier’s Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, as the deactivation was justified. In making this determination, the contractor shall consider, at minimum, the following.*
  - a. Whether the deactivation was implemented after 90 days of when the change of enrollment information occurred.*
  - b. Whether the letter notifying the provider or supplier of the deactivation was sent to the correct address as instructed in section 15.24.*
  - c. Whether the enrollment changes were received in an enrollment application that was processed to completion within 90 days of when the change of enrollment occurred.*

*Consider the following example:*



*Dr. Happy has reassigned his benefits to physician group Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on April 15, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal to the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.*

*In this scenario, the deactivation was correctly implemented after 90 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 90 days of the change of enrollment information. Though an application was received within 90 days of the change of enrollment information, that application was not processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.*

- 3) *For deactivations under 42 C. F. R. 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following.*
- a. Whether the deactivation was implemented after 90 days of the revalidation request.*
  - b. Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 15.24.*
  - c. Whether a revalidation application was timely received that was processed to completion.*

*Consider the following example:*

*On January 1, 2018, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2018. The contractor receives a revalidation application from Dr. Great on March 1, 2018. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2018 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2018. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.*

*The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contractor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission shall be sent via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.*

*If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider or supplier's Medicare billing privileges within ten business days of the date the favorable determination is issued. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the*

*contractor issues a rebuttal determination unfavorable to the provider or supplier, the provider's or supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.*

*If additional information/documentation is needed prior to reinstating the provider or supplier (e.g. deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in their rebuttal determination letter. The contractor shall not reinstate the provider or supplier 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 rebuttal determination, the contractor shall contact the provider or supplier 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 contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.*

#### ***D. Rebuttal Determination is Not Subject to Further Review***

*Pursuant to the rebuttal regulation at 42 C.F.R. § 405.375(c), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Therefore, no additional appeal rights shall be included on any rebuttal determination letter.*

### ***15.27.5.2 – Rebuttal Model Letters***

***(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)***

#### ***A. Instruction***

*For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.*

#### ***B. Rebuttal Signature Development Model Letter***

*(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 rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

***Re: Rebuttal Determination***

***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 rebuttal]:

*We are in receipt of your rebuttal 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 15.27.5.1. [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal 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 rebuttal 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 rebuttal submission may be dismissed.*

*(If the submission is missing a signed written notice from the provider/supplier authorizing the legal 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 rebuttal submission may be dismissed.*

*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]*

### ***C. Rebuttal Further Information Required Development Model Letter***

*(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 rebuttal.]*

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

*[Month] [DD], [YYYY]*

*[Provider/Supplier/Attorney/Firm Name]*

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

*[Address] (Address from which the rebuttal was sent)*

*[City], [State] [Zip Code]*

***Re: Rebuttal Determination***

***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 rebuttal]:***



On [Month] [DD], [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal 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]

#### **D. Rebuttal Moot Model Letter**

(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 rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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 rebuttal]:

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

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]*

***E. Rebuttal Withdrawn Model Letter***

*(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 rebuttal.]*

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

*[Month] [DD], [YYYY]*

*[Provider/Supplier/Attorney/Firm Name]*

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

*[Address] (Address from which the rebuttal was sent)*

*[City], [State] [Zip Code]*

***Re: Rebuttal Determination***

***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 rebuttal]:*

*We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.*

*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]*

***F. Rebuttal Receipt Acknowledgement Model Letter***

*(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 rebuttal.]*

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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 rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

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]

### **G. Final Rebuttal Decision Email Template**

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

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

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

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

Please see the attached determination regarding your rebuttal.

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]

## **H. Rebuttal Dismissal Model Letters**

### **1. Untimely**

(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 rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

**Re: Rebuttal Determination**

**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 rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 20 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

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]

### **2. Improper Signature**

(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 rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]  
[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

**Re: Rebuttal Determination**

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 rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within 20 calendar days of the date of the deactivation letter.

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]

### **3. No Rebuttal Rights**

(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 rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

*Re: Rebuttal Determination*

*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 rebuttal]:*

*This letter is in response to the rebuttal received by [MAC Name].*

*[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.*

*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]*

#### ***4. More than One Submission***

*(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 rebuttal.]*

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

*[Month] [DD], [YYYY]*

*[Provider/Supplier/Attorney/Firm Name]*

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

*[Address](Address from which the rebuttal was sent)*

*[City], [State] [Zip Code]*

*Re: Rebuttal Determination*

*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 rebuttal]:*

*This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].*

*[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 15 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per*

deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

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]

### **I. Rebuttal Not Actionable Model Letter (Moot)**

(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 rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

Re: Rebuttal Determination

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 rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

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]

**J. Favorable Rebuttal Model Letter**

(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 rebuttal.]

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

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

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

[City], [State] [Zip Code]

**Re: Rebuttal Determination**

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 rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination 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.

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)(1-3)

**OTHER APPLICABLE AUTHORITIES:**

- 42 C.F.R. §
- Medicare Program Integrity Manual (MPIM) chapter 15.XX (If applicable).

**EXHIBITS:**

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(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 other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)



## **BACKGROUND:**

*The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination 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 rebuttal.)*

## **REBUTTAL ANALYSIS:**

*(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)*

## **DECISION:**

*(A short conclusory restatement.)*

*(Example: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges is not justified based on the information available.*

*This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]'s 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 rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)*

*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]*

## **K. Unfavorable Rebuttal Model Letter**

*(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 rebuttal.]*

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

*[Month] [DD], [YYYY]*

*[Provider/Supplier/Attorney/Firm Name]*

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

*[Address](Address from which the Rebuttal was sent)*

*[City], [State] [Zip Code]*

*Re: Rebuttal Determination*

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

*NPI: [XXXXXXXXXX]*

*PTAN: [XXXXX]*

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

*Dear [Person(s) who submitted the rebuttal]:*

*This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination 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.*

***DEACTIVATION REASON:***

- 42 C.F.R. § 424.540(a)(1-3)*

***OTHER APPLICABLE AUTHORITIES:***

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

***EXHIBITS:***

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);*
- Exhibit 2: (Example: Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).*

*(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 other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)*

***BACKGROUND:***

*The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination 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 rebuttal.]*

***REBUTTAL ANALYSIS:***

*(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)*

**DECISION:**

*(A short conclusory restatement.)*

*(Example: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-3) is justified.)*

*This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.*

*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]*

**15.27.5.3 – Rebuttal Reporting Requirements**

***(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)***

**A. Monthly**

*Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column should be left blank.*

*The response in the column labelled “Final Decision Result” should be one of the following:*

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved.*
- **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation was not justified and the enrollment record has been placed back into an approved status.*
- **Unfavorable (to provider/supplier):** MAC has determined that the deactivation was justified and the enrollment record remains deactivated.*

- **Dismissed:** *The appeal does not meet the rebuttal submission requirements. (Ex: incorrect signature, untimely, not rebuttable, etc.*
- **Rescinded:** *MAC has received instruction from CMS to rescind the deactivation and return the enrollment record to an approved status.*
- **Withdrawn:** *Provider/supplier has submitted written notice of its intent to withdraw its rebuttal.*

*The reports shall be sent to CMS via email at [ProviderEnrollmentAppeals@cms.hhs.gov](mailto:ProviderEnrollmentAppeals@cms.hhs.gov) no later than the 15<sup>th</sup> of each month; the report shall cover the prior month's rebuttal submissions (e.g., the February report shall cover all January rebuttals). If this day falls on a weekend or a holiday, the report must be submitted the following business day.*

**PLEASE INCLUDE THIS COMPLETED PROVIDER ENROLLMENT FORM  
WITH THE SUBMISSION OF REBUTTAL**



**Provider/Supplier Name:** \_\_\_\_\_

**National Provider Identifier (NPI):** \_\_\_\_\_ **PTAN:** \_\_\_\_\_

**Document Control Number (DCN):** \_\_\_\_\_

**Submitter's Email Address:** \_\_\_\_\_

**Submitter's Address:** \_\_\_\_\_

**Submitter's Fax Number (If Applicable):** \_\_\_\_\_

**Medicare Administrative Contractor:** [Insert MAC Name] \_\_\_\_\_

At minimum, the rebuttal submission must:

- 1) Be received within 20 calendar days from the date of the deactivation notice;
- 2) Specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement;
- 3) Include all documentation and information the provider or supplier would like to be considered in reviewing the deactivation;
- 4) 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. The provider's or 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 rebuttal request. If the legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to constitute notice. If the legal representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with CMS. This notice of appointment must be signed and dated by the individual provider or supplier, the authorized or delegated official, or a legal representative.

Please send this form, the rebuttal submission, the deactivation letter, and all supporting documentation applicable to the rebuttal of the deactivation to the address noted in your deactivation letter, which is also listed below:

[MAC Address]

You may also email this form, the rebuttal submission, the deactivation letter, and all supporting documentation applicable to the rebuttal of the deactivation to the email address listed below:

[MAC Email Address]

You may also fax this form, the rebuttal submission, the deactivation letter, and all supporting documentation applicable to the rebuttal of the deactivation to the fax number listed below:

[MAC Fax Number]



**Final Determination Result**

Not Actionable  
Favorable  
Unfavorable  
Dismissed  
Rescinded  
Withdrawn

**MAC**

CGS  
FCSO  
NGS JK  
NGS J6  
Noridian JE  
Noridian JF  
Novitas JH  
Novitas JL  
NSC  
Palmetto JM  
Palmetto JJ  
WPS J5  
WPS J8

**Regulatory Authority for Deactivation**

424.540(a)(1)  
424.540(a)(2)  
424.540(a)(3)