

<b>CMS Manual System</b>	Department of Health & Human Services (DHHS)
<b>Pub 100-08 Medicare Program Integrity</b>	Centers for Medicare & Medicaid Services (CMS)
<b>Transmittal 251</b>	<b>Date: APRIL 11, 2008</b>
	<b>Change Request 5826</b>

**SUBJECT: Administrative Appeals for Provider Enrollment**

**I. SUMMARY OF CHANGES:** Chapter 10 incorporates the new appeal provisions of Section 936 of the MMA and has been revised to provide instructions on issuing more detailed denial, revocation and reconsideration letters. The submission of corrective action plans and filing requirements are also addressed.

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE: May 12, 2008**

**IMPLEMENTATION DATE: May 12, 2008**

*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**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	10/19/Administrative Appeals
<b>D</b>	10/19.1/Model Letter Formation

**III. FUNDING:**

**SECTION A: For Fiscal Intermediaries and Carriers:**

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

**SECTION B: For Medicare Administrative Contractors (MACs):**

The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

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

# Attachment - Business Requirements

<b>Pub. 100-08</b>	<b>Transmittal: 251</b>	<b>Date: April 11, 2008</b>	<b>Change Request: 5826</b>
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**SUBJECT: Administrative Appeals for Provider Enrollment**

**Effective Date: May 12, 2008**

**Implementation Date: May 12, 2008**

## I. GENERAL INFORMATION

**A. Background:** Section 936 of the Medicare Modernization Act (MMA) establishes an appeals process for providers and suppliers whose Medicare enrollment application has been denied or Medicare billing privileges revoked.

**B. Policy:** Chapter 10, Section 19 incorporates the new appeal provisions of Section 936 of the MMA and has been revised to provide instructions on issuing more detailed denial, revocation and reconsideration letters. The submission of corrective action plans (CAPS) and filing requirements are also addressed.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER	
							F I S S	M C S	V M S	C W F		
5826.1	Contractors shall include in their denial/revocation letters (or recommended denial/revocation letters) a clear explanation of why the application is being denied/revoked including the regulatory basis and how to submit a CAP.	X		X	X							RO NSC
5826.2	Contractors shall revoke a provider or certified supplier's billing privileges if they are found not to be in compliance with Medicare requirements.	X		X								RO
5826.3	Contractors shall cc the RO and their CMS contractor liaison on revocation letters sent to providers and certified suppliers.	X		X								
5826.4	Contractors shall accept the submission of a corrective action plan submitted within 30 days for providers and suppliers and 15 days for DMEPOS suppliers.	X		X	X							RO NSC
5826.5	If submitted concurrently, contractors shall first process the CAP and then the reconsideration request.	X			X							RO NSC
5826.5.1	The contractor and HO/RO shall coordinate prior to acting on a CAP or reconsideration request to determine if the other party received anything.	X		X	X							RO NSC
5826.5.2	Contractors shall notify the provider or supplier, by letter, of their decision to approve/deny their CAP	X		X	X							RO NSC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	request.										
5826.6	Contractors shall extend the filing period for a reconsideration an additional 5 days to allow for mail time.	X			X						RO NSC
5826.7	Contractors shall not reject a reconsideration request received on the last day of filing that falls on a holiday or weekend.	X			X						RO NSC
5826.8	Contractors shall not introduce new denial/revocation reasons during the reconsideration process or change a denial/revocation reason listed in the initial determination.	X		X	X						RO NSC
5826.9	Contractors shall not request an appeal to the Administrative Law Judge (ALJ).	X			X						RO NSC
5826.10	The HO shall re-state, in their reconsideration decision letter, the facts and findings determined by the contractor in their initial determination.	X			X						RO NSC

### III. PROVIDER EDUCATION TABLE

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

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

### V. CONTACTS

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

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

## **VI. FUNDING**

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

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

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

The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## 19 - Administrative Appeals

*(Rev. 251, Issued: 04-11-08; Effective/Implementation Date: 05-12-08)*

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that determination. This appeal process applies to all providers and suppliers, not just those defined in 42 CFR §498, and ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a *reconsideration* decision to an administrative law judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers then can seek review by the Departmental Appeals Board (DAB) and then may request judicial review.

### *Denial/Revocation of Medicare Billing Privileges*

#### **A. Carriers (including NSC and A/B MACs)**

If a contractor reviews an initial enrollment application for a provider or supplier and finds a basis for denying the application pursuant to 42 CFR §424.530, such as; the provider or supplier does not meet one or more of the Federal or State requirements, the contractor *shall* deny the application and send a denial letter *to the provider or supplier*. *The denial letter shall contain:*

- *a clear explanation of why the application is being denied,*
- *the regulatory basis to support each reason or reasons for the denial,*
- *an explanation of how the provider or supplier does not meet the enrollment criteria or requirements to enroll,*
  - *how to submit a corrective action plan (CAP) and*
  - *information regarding appeal rights including the procedures for requesting a contractor reconsideration.*

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

- *a clear explanation of why Medicare billing privileges are being revoked,*
- *the regulatory basis to support each reason or reasons for the revocation,*
- *an explanation of how the provider or supplier no longer meets the enrollment criteria or requirements for billing privileges,*
  - *the effective date of the revocation (30 days from the date the notice is mailed, or 15 days from the date the notice is mailed for DMEPOS suppliers),*
  - *how to submit a CAP, and*

- *information about* appeal rights *including the* procedures for requesting a contractor reconsideration.

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

The contractor, including the NSC, shall accept, *for review*, the submission of a CAP for denied or revoked billing *privileges if the CAP is submitted within 30 days from the date of the notice for providers and suppliers or 15 days from the date of the notice for DMEPOS suppliers*. Submission of a CAP shall contain, at a minimum, verifiable evidence of provider or supplier compliance *with enrollment requirements*. If a CAP for a denied application is approved by a contractor, billing privileges can be issued and *be made* retroactive to the date *the provider or supplier came into compliance with enrollment requirements or as of the date it is awarded by the NSC*. If a CAP *for revoked billing privileges is approved, billing privileges can be restored and made retroactive to the date the provider or supplier came into compliance with enrollment requirements*. CMS's approval is required *prior to restoring billing privileges*.

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

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

### **Request for Reconsideration (formerly Contractor Hearing)**

A provider or supplier that wishes to request a reconsideration must file its request, in writing, with the contractor within 60 days after the postmark of the notice to be considered timely filed. A DMEPOS supplier must file its request within 90 days after the postmark of the notice to be considered timely filed. *Contractors shall extend the filing period an additional 5 days to allow for mail time. Reconsideration requests submitted on the 65<sup>th</sup> day or the 95<sup>th</sup> day of which falls on a weekend or holiday should*

*still be considered timely filed and not rejected.* The date the request is received by the contractor is treated as the date of filing. The request must be signed by the physician, non-physician practitioner, or any responsible authorized official within the entity. For DMEPOS suppliers, the request must be signed by the authorized representative, delegated official, owner or partner. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

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

***NOTE: The NSC reconsiderations only are conducted by a HO.***

Upon receipt of the reconsideration, the *contractor/HO* shall send a letter to the provider or supplier to acknowledge receipt of their request. In its acknowledgment letter, the *contractor/HO* shall advise the requesting party that the reconsideration will be conducted and a determination issued as soon as possible, but no later than 90 days from the date of the request. The *contractor/HO* shall include a copy of its acknowledgment letter in the reconsideration file. A model acknowledgment letter can be found in §19.1. The language therein may need to be modified, depending upon: (1) whether it is the *contractor/HO* assigned to the case that is sending out the acknowledgment, and (2) any special circumstances involved in the case.

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

In reviewing an initial enrollment decision or a revocation, *the contractor/HO* should limit the scope of its review to the contractor's reason for imposing a denial or revocation at the time it issued the action and whether the contractor made the correct decision (i.e., denial/revocation). *Contractors cannot introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.* If a provider or supplier provides evidence that demonstrates or proves that they met or maintained compliance after the date of denial or revocation, the *contractor/HO* shall exclude this information from the scope of *its* review.

If a request for reconsideration is filed late, the *contractor/HO shall* make a finding of good cause before taking any other action on the appeal. The time limits may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows, or the party alleges and the record does not negate that the delay in filing was due to one of the following:



- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or
- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

The *contractor/HO shall* issue a written decision as soon as practicable, but no later than 90 days from the date of the request and forward the decision to the contractor and by certified mail to the provider, supplier or *the* authorized representative. *The reconsideration letter should include: (i) the re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in their initial determination; (ii) a clear explanation of why the contractor/HO is upholding or overturning the denial or revocation action; (iii) if applicable, the regulatory basis to support each reason or reasons for the denial (iv) an explanation of how the provider or supplier does not meet the enrollment criteria or requirements to enroll; (v) the information about the provider or supplier's further right to appeal the denial or revocation; (vi) the address to which the written appeal must be mailed; (vii) the date by which the appeal must be filed; and (viii) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision.)*

A request for reconsideration may be withdrawn at any time prior to the mailing of the reconsideration decision either by the party that filed the appeal request or their authorized representative. The request for withdrawal must be in writing, signed, and filed with the contractor.

When the contractor receives a withdrawal request, it sends a letter to the provider or supplier acknowledging its receipt and advising that *the* reconsideration action will be terminated.

Contractors shall maintain a report detailing the number of reconsideration requests they receive and their outcome (e.g., decision withheld, reversed, or further appeal requested *or requests withdrawn*). Contractors are not required to submit this information to *CO* but it must be provided upon request.

### **Request for Administrative Law Judge (ALJ) Hearing**

If the provider or supplier is not in agreement with the reconsidered determination, a further appeal can be filed with an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

Department of Health and Human Services

Departmental Appeals Board (DAB)  
Civil Remedies Division, Mail Stop 6132  
330 Independence Avenue, S.W.  
Cohen Bldg, Room G-644  
Washington, D.C. 20201  
ATTN: CMS Enrollment Appeal

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

Upon receipt of the request to file an ALJ hearing, an ALJ at the DAB will issue a letter by certified mail to the provider or supplier, CMS and the regional office of General Counsel (OGC) *acknowledging receipt of an appeals request and* detailing a scheduled pre-hearing conference. The OGC will assign an attorney that will represent CMS during the *appeal's process* and also *will* serve as the DAB point of contact. CMS nor the contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing conference to discuss any issues. The contractors shall work with and provide the OGC attorney with all necessary documentation. Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS.

### **Request for Departmental Appeals Board (DAB) Hearing**

If *a provider or supplier is dissatisfied with the ALJ decision, then that party* may request a *review by the* DAB. A provider *or* supplier that wishes to request a review by the DAB must file its request within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing. The DAB may admit additional evidence into the record if the *DAB* considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. *If additional information is presented orally to the DAB, then a transcript will be prepared* and made available to any party upon request.

### **Request for Judicial Review**

Any provider or supplier dissatisfied with a DAB decision has a right to seek judicial review by timely filing a civil action in a United States District Court. The time limit for filing is 60 days from receipt of the notice of the DAB's decision.

### **B. Fiscal Intermediary (*including A/B MACs*)**

If a contractor reviews an initial enrollment application for a provider or certified supplier and finds that the application *should* be denied pursuant to 42 CFR §424.530, such as; a facility's failure to meet one or more of the Federal or State requirements, then the contractor sends a recommendation for denial to the RO. If the RO finds that the contractor's recommendation is consistent with the applicable rules and regulations, a denial letter is sent to the provider or certified supplier *by the RO. The denial letter shall contain:*

- *a clear explanation of why the application is being denied,*
- *a regulatory basis to support each reason or reasons for the denial,*
- *an explanation of how the provider or certified supplier does not meet the enrollment criteria or requirements to enroll,*
- *how to submit a corrective action plan (CAP), and*
- *information regarding appeal rights including the procedures for requesting RO reconsideration.*

*Similarly, when a contractor discovers that there is a basis for revoking a provider or certified supplier's billing privileges, such as; a provider or certified supplier that no longer meets one of the requirements for billing privileges, the provider or certified supplier's billing privileges is revoked and a revocation letter is sent to the provider or certified supplier by the contractor with a cc to the RO and the CMS contractor liaison. The revocation letter must contain:*

- *a clear explanation of why Medicare billing privileges are being revoked,*
- *the regulatory basis to support each reason or reasons for the revocation,*
- *an explanation of how the provider or certified supplier no longer meets the enrollment criteria or requirements for billing privileges,*
- *the effective date of the revocation (30 days from the date the notice is mailed)*
- *how to submit a CAP, and*
- *information about appeal rights including the procedures for requesting an RO reconsideration.*

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

The *contractor or the RO* shall accept, *for review*, the submission of a CAP for denied or revoked billing *privileges if the CAP is submitted within 30 days from the date of the notice*. Submission of a CAP shall contain, at a minimum, verifiable evidence of the provider or certified *supplier's compliance with enrollment requirements*. If a CAP for a denied application is approved by *the RO*, billing privileges can be issued *once the provider or certified supplier has passed the state survey and been issued a certification date*. If a CAP for revoked billing privileges is approved, *billing privileges can be restored and made retroactive to the date the provider or certified supplier came into*

*compliance with enrollment requirements. CMS approval is required prior to restoring billing privileges.*

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

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

### **Request for RO Reconsideration**

A provider or certified supplier that wishes to request a reconsideration must file its request, in writing, with the RO within 60 days after the postmark of the notice to be considered timely filed. *The RO shall extend the filing period an additional 5 days to allow for mail time. Reconsideration requests submitted on the 65<sup>th</sup> day of which falls on a weekend or holiday shall still be considered timely filed and not rejected.* The date the request is received by the RO is treated as the date of filing. The request may be signed by the authorized official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

Upon receipt of the reconsideration, the RO shall send a letter to the provider or certified supplier to acknowledge receipt of their request. In its acknowledgment letter, the RO shall advise the requesting party that the reconsideration will be conducted and a determination issued as soon as possible, but no later than 90 days from the date of the request. The RO shall include a copy of its acknowledgment letter in the reconsideration file. A model acknowledgment letter can be found in §19.1.

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

In reviewing an initial enrollment decision or a revocation, a RO should limit the scope of its review to the *contractor or the RO's initial* reason for imposing a denial or revocation at the time that it issued the action and whether the *contractor or RO* made the correct decision (i.e., denial/revocation). *The contractor or the RO cannot introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.* If a provider or *certified* supplier provides evidence that demonstrates or proves that they met or maintained compliance, after the date of denial or revocation, the RO shall exclude this information from the scope of its review.

If a reconsideration request is filed late, the RO shall make a finding of good cause before taking any other action on the appeal. These time limits may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows, or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or
- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

The RO *shall* issue a written decision as soon as practicable, but no later than 90 days from the date of the request and forwards the decision by certified mail to the contractor, the provider, certified supplier or *the* authorized representative. *The reconsideration letter should include: (i) the re-stated facts and findings, including regulatory basis for the action as determined by the RO in their initial determination; (ii) a clear explanation of why the RO is upholding or overturning the denial or revocation action; (iii) if applicable, the regulatory basis to support each reason or reasons for the denial or revocation; (iv) an explanation of how the provider or certified supplier does not meet the enrollment criteria or requirements to enroll; (v) the information about the provider or certified supplier's further right to appeal the denial or revocation; (vi) the address to which the written appeal must be mailed; (vii) the date by which the appeal must be filed; and (viii) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision.)*

A request for reconsideration may be withdrawn at any time prior to the mailing of the reconsideration decision either by the party that filed the appeal request or their authorized representative. The request for withdrawal must be in writing, signed, and filed with the RO.

When the RO receives a withdrawal request, it sends a letter to the provider or certified supplier acknowledging its receipt and advising that *the* reconsideration action will be terminated.

The RO shall maintain a report detailing the number of reconsideration requests they receive and their outcome (e.g., decision withheld, reversed, or further appeal requested *or requests withdrawn*). The RO is not required to submit this information to *CO* but it must be provided upon request.

### **Request for ALJ Hearing**

If the provider or certified supplier is not in agreement with the reconsidered determination a further appeal can be filed with an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such appeal must be filed, in writing, within 60 days from the receipt of the reconsideration decision. ALJ requests should be sent to:

Department of Health and Human Services  
Departmental Appeals Board (DAB)  
Civil Remedies Division, Mail Stop 6132  
330 Independence Avenue, S.W.  
Cohen Bldg, Room G-644  
Washington, D.C. 20201  
ATTN: CMS Enrollment Appeal

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

Upon receipt of the request to file an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider or certified supplier, *CMS*, the RO and the OGC *acknowledging receipt of an appeals request and* detailing a scheduled prehearing conference. The OGC will assign an attorney that will represent *CMS* during the *appeal's process* and also *will* serve as the DAB point of contact. *CMS*, the RO, nor the contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing conference to discuss any issues. The contractor shall work with and provide the OGC attorney with all necessary documentation. Any settlement proposals, as a result of the pre-hearing conference, will be addressed with *CMS*.

### **Request for DAB Hearing**

*If a provider or certified supplier is dissatisfied with the ALJ's decision, then that party may request review by the DAB.* A provider or certified supplier that wishes to request a review by the DAB must file its request within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing. The DAB may admit additional evidence into the record if the *DAB* considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. *If additional information may be presented orally to the DAB then a transcript will be prepared* and made available to any party upon request.

### **Request for Judicial Review**

Any provider or certified supplier dissatisfied with DAB review has a right to seek judicial review by timely filing a civil action in a United States District Court. The time limit for filing is 60 days from receipt of the notice of the DAB's decision.