CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10735	**Date: April 27, 2021**
	Change Request 12157

SUBJECT: Updates to Medicare Administrative Contractor (MAC) Appeals and Rebuttals Reporting

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the reporting templates for MAC received and processed appeals, as well as rebuttals and includes further clarification on how to complete each template.

EFFECTIVE DATE: May 27, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 27, 2021

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.6/10.6.18/Appeals Process
R	10/10.6/10.6.19/Other Medicare Contractor Duties

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: 10735	Date: April 27, 2021	Change Request: 12157

SUBJECT: Updates to Medicare Administrative Contractor (MAC) Appeals and Rebuttals Reporting

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I. GENERAL INFORMATION

A. Background: As part of processing and issuing decisions in response to provider/supplier submitted reconsideration requests, corrective action plans (CAPs), and rebuttals, MACs are required to submit monthly reports to CMS detailing the number and outcome of each appeal and rebuttal.

B. Policy: There are no regulatory, legislative, or statutory requirements related to this CR.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12157.1	The contractor shall send a monthly report containing all provider enrollment appeals received during the previous month except those referred to CMS for processing, as well as any appeals for which a final outcome/decision was not previously reported to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month.	X	X							NSC
12157.2	The contractor shall utilize the provider enrollment appeals reporting template in completing each monthly report.	X	X							NSC
12157.2.1	The contractor shall use one of the following: Denial,	X	X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Revocation, Effective Date, or Other for the response reported in Column A, "Initial Determination Type," on the provider enrollment appeals reporting template.									
12157.2.1.1	The contractor shall provide an explanation in Column N, "Comments," if the contractor uses Other for the response in Column A.	X	X							NSC
12157.2.1.2	The contractor shall use "N/A" for the response in Column G, "Regulatory Authority (As identified on initial determination)," if the contractor uses Other for the response in Column A.	X	X							NSC
12157.2.2	The contractor shall use one of the following: Not Actionable, Favorable, Unfavorable, Dismissed, Rescinded, or Withdrawn for the response in Column L, "Final Decision Result," on the provider enrollment appeals reporting template.	X	X							NSC
12157.2.2.1	The contractor shall use "In Process" in Column L if a final decision has not yet been rendered for an appeal at the time the report is sent to CMS.	X	X							NSC
12157.2.2.2	The contractor shall use "In Process" in Column M if a final decision has not yet been rendered for an appeal at the time the report is sent to CMS.	X	X							NSC
12157.2.2.3	The contractor shall use "Not yet sent" in Column K if a receipt acknowledgement	X	X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	email/letter has not yet been sent to the provider/supplier/legal representative at the time the report is sent to CMS or "N/A" if a receipt acknowledgement email/letter is not required to be sent for a particular case.									
12157.2.3	The contractor shall use one of the following formats: CGS, FCSO, NGS JK, NGS J6, Palmetto JM, Palmetto JJ, NSC, WPS J8, WPS J5, Noridian JE, Noridian JF, Novitas JH, or Novitas JL for the response in Column F, "MAC (Including Jurisdiction)," on the provider enrollment appeals reporting template.	X	X							NSC
12157.2.4	The contractor shall use the following format for the response in Column G, "Regulatory Authority (As identified on initial determination)," for an effective date appeal: 42 Code of Federal Regulations (CFR) 424.520.	X	X							NSC
12157.2.5	The contractor shall use the following format for the response in Column G, "Regulatory Authority (As identified on initial determination)," for a denial appeal with only one authority cited in the initial determination: 42 CFR 424.530(a)(1-15).	X	X							NSC
12157.2.6	The contractor shall use the following format for the response in Column G, "Regulatory Authority (As	X	X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	identified on initial determination)," for a denial appeal with multiple authorities cited in the initial determination: 42 CFR 424.530(a)(1-15)(1-15).									
12157.2.7	The contractor shall use the following format for the response in Column G, "Regulatory Authority (As identified on initial determination)," for a revocation appeal with only one authority cited in the initial determination: 42 CFR 424.535(a)(1-22).	X	X							NSC
12157.2.8	The contractor shall use the following format for the response in Column G, "Regulatory Authority (As identified on initial determination)," for a revocation appeal with multiple authorities cited in the initial determination: 42 CFR 424.535(a)(1-22)(1-22).	X	X							NSC
12157.2.9	The contractor shall ensure that all columns are completed on each monthly provider enrollment appeals report.	X	X							NSC
12157.2.10	The contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov with any questions concerning how to complete the monthly provider enrollment appeals report.	X	X							NSC
12157.3	The contractor shall send a monthly report containing all provider enrollment rebuttals received during the previous month, as well as any	X	X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	rebuttals for which a final outcome/decision was not previously reported to CMS via email at ProviderEnrollmentAppeals @cms.hhs.gov no later than the 15th of each month.									
12157.4	The contractor shall ensure that all columns are completed on each monthly provider enrollment rebuttals report.	X	X							NSC
12157.5	The contractor shall continue to include all provider enrollment rebuttals on each monthly report (even if the rebuttal was received in an earlier month) until a final decision/outcome is reported to CMS.	X	X							NSC
12157.5.1	The contractor shall use one of the following for the response in Column J, "Final Decision Result," on the monthly provider enrollment rebuttal report: Not Actionable, Favorable, Unfavorable, Dismissed, Rescinded, or Withdrawn, unless a decision has not been issued then the response shall be "In Process."	X	X							NSC
12157.5.2	The contractor shall use "In Process" for the response in Column I, "Date Rebuttal Determination Issued," if a rebuttal decision has not been issued at the time the report is sent to CMS.	X	X							NSC
12157.5.3	The contractor shall use one of the following formats in the response in Column E, "MAC (Including	X	X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Jurisdiction)," on the monthly rebuttal report: CGS, FCSO, NGS JK, NGS J6, Palmetto JM, Palmetto JJ, NSC, WPS J8, WPS J5, Noridian JE, Noridian JF, Novitas JH, or Novitas JL.									
12157.5.4	The contractor shall use one of the following formats in the response in Column F, "Regulatory Authority (As identified on initial determination)," on the monthly rebuttal report: 42 CFR 424.540(a)(1); 42 CFR 424.540(a)(2); 42 CFR 424.540(a)(3); or N/A.	X	X							NSC
12157.5.4.1	The contractor shall provide an explanation in Column K, "Comments," if the contractor uses N/A as the response in Column F due to the rebuttal being submitted in response to an enrollment action that does not afford rebuttal rights.	X	X							NSC
12157.6	The contractor shall use "Not yet sent" in Column H if a receipt acknowledgement email/letter has not yet been sent to the provider/supplier/legal representative at the time the report is sent to CMS or N/A if a receipt acknowledgement email/letter is not required to be sent for a particular case.	X	X							NSC
12157.7	The contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov with any questions concerning how to complete the monthly provider enrollment rebuttals	X	X							NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	report.									

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Timothy Trego, 410-786-8976 or Timothy.Trego@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 2

Medicare Program Integrity Manual
Chapter 10 - Medicare Enrollment

Table of Contents
(Rev.10735; 04-27-2021)

Transmittals for Chapter 10

10.6.18 – Appeals Process

(Rev. 10735; 04-27- 21; Effective: 05-27-21; Implementation: 05-27-21)

A. Review Procedures for Determinations that Affect Participation in the Medicare Program

1. Background

This review process of initial determinations applies to all providers and suppliers and ensures that all current and prospective providers and suppliers receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request Administrative Law Judge (ALJ) review of a reconsideration decision within the Civil Remedies Division of the Departmental Appeals Board (CRD DAB). Providers and suppliers may thereafter seek review of the ALJ decision in the Appellate Division of the Departmental Appeals Board (DAB) and may then request judicial review in Federal District Court.

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

Any corrective action plan (CAP) or reconsideration request that purports to challenge an enrollment action other than the initial determinations identified above (including inclusion on the CMS Preclusion List and Opt-Out Status) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The Medicare Administrative Contractor (MAC) shall take no action on the provider's or supplier's information on its enrollment record regarding an appeal submission for revocations forwarded to CMS for processing unless otherwise instructed by the Provider Enrollment and Oversight Group (PEOG).

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

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

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

- All CAPs and reconsideration requests for certified providers/suppliers (as defined in Sections 10.2.1 and 10.2.2 of this chapter) and institutional providers/suppliers which have been revoked (as defined in Section 10.4(M)(2)(e) of this chapter);

- CAPs and reconsideration requests for Independent Diagnostic Testing Facilities;

- CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPP);

- CAPs and reconsideration requests for Opioid Therapy Programs (OTPs);

- Reconsideration requests for enrollment denials pursuant, in whole or in part, to 42 C.F.R. § 424.530(a)(2), (3), (6), (11), (12), (13), and (14);

- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), (21) and (22);

- Requests for reversals of denials pursuant to 42 C.F.R. § 424.530(c) and/or revocations pursuant to 42 C.F.R. § 424.535(e);

- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);

- Reconsideration requests challenging the addition of years to an existing re-enrollment bar;

- Reconsideration requests challenging whether an individual or entity other than the provider or supplier that is the subject of the second revocation was the actual subject of the first revocation;

- Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in § 422.2 or § 423.100; and

- Reconsideration requests regarding opt-out status.

If the provider or supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), (5) or (9), in conjunction with any denial or revocation reason(s) listed above, those CAPs and/or reconsideration requests should also be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt and the determination will be rendered by CMS. If the provider or supplier only submits a CAP for the noncompliance portion of any initial determinations listed above, the CAP must be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of

receipt, even if the provider or supplier does not submit a reconsideration request. The MAC shall not process the CAP if it is required to be forwarded to CMS. If the provider or supplier later submits a reconsideration request, the reconsideration request must also be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt.

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

(**NOTE:** This includes all CAPs and reconsideration requests for DMEPOS suppliers that fit the criteria identified above. In addition, as also indicated above, CAPs may only be submitted for denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocations pursuant to 42 C.F.R. § 424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), (21), or (22) the submission should still be forwarded to CMS within 10 business days of the date of receipt to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.)

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

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

2. Reopening and Revising CAP and Reconsideration Determinations

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

3. Requests to the MACs

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

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

- A copy of the initial determination letter**;**
- A chronological timeline outlining: (1) the processing of applications; (2) the date they began providing services at the newest assigned location; and (3) if there were development requests;

- The hearing officer's decision as well as the provider or supplier's CAP and/or reconsideration request;

- A complete copy of all application Form CMS-855s, and any supporting documentation submitted with the provider or supplier's application;

- All background information and investigative data the hearing officer used to make their decision. Including any on-site visit reports; the MAC's recommendation for administrative action based on the on-site visit;

- Contact information for the person(s) who signed both the revocation and reconsideration decision letters.

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

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

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

4. Timing of CAP and Reconsideration Request Submissions

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

The mailing and email address for all CAPs and reconsideration requests to be rendered by CMS identified in section 10.6.18(A) is:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Attn: Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review, and may result in the dismissal of any untimely submitted

reconsideration request. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to circumstances outside of the provider's or supplier's control such as the following:

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

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

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

5. Time Calculations

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

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

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

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

6. Signatures

A CAP and/or reconsideration request must be submitted in the form of a letter that is signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative, as defined in 42 C.F.R. § 498.10. If the representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the representative

is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic.

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

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

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

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

7. Representative for CAP and/or Reconsideration Request

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

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

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

applications received while the provider or supplier is in a revoked status should be returned to the provider or supplier and not processed pursuant to Section 10.4(H)(1).

B. Corrective Action Plans (CAPs)

1. Background

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

2. Requirements for CAP Submission

CAP submission:

(a) Must contain, at a minimum, verifiable evidence that the provider or supplier is in compliance with all applicable Medicare requirements;

(b) Must be received within 35 calendar days from the date of the initial determination (see section 10.6.18(A)(4) for clarification on timing). The contractor shall accept a CAP via hard-copy mail, email, and/or fax;

(c) Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

(d) Should include all documentation and information the provider or supplier would like to be considered in reviewing the CAP.

(e) For denials, the denial must be based on 42 C.F.R. § 424.530(a)(1);

i. For denials based on multiple grounds of which one is § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter (If multiple grounds are involved of which one is § 424.530(a)(1), the MAC shall:

A. Only consider the portion of the CAP pertaining to § 424.530(a)(1). The other denial bases may only be reviewed as a reconsideration.

(f) For revocations, the revocation must be based on 42 C.F.R. § 424.535(a)(1);

i. Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted.

A. For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to 424.535(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgment

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

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

3. Receipt Acknowledgment of CAP

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

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

4. Dismissing a CAP

A CAP shall be dismissed when the provider or supplier does not have the right to submit a CAP for the initial determination, or when the provider or supplier submitted the CAP improperly or untimely (see Section 10.6.18(B)(2)). As a result, the CAP shall not be reviewed. The MAC shall use the model dismissal letter when dismissing a CAP. All unacceptable CAPs shall be dismissed as soon as possible.

If a provider or supplier concurrently submits a CAP and reconsideration request, but the initial determination being appealed does not afford CAP rights or the CAP submission is untimely, the MAC shall dismiss the CAP using the No CAP Rights Dismissal Model Letter or Untimely CAP Dismissal Model Letter and review the reconsideration request in accordance with the instruction in Section 10.6.18(C).

5. CAP Analysis

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

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

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

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

6. Processing and Approval of CAPs

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

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

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

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

a. Denials

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

March 20.

b. Revocations

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

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

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

7. Withdrawal of CAP

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

8. Concurrent Submission of CAP and Reconsideration Request

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

If a CAP and a reconsideration request (see Section 10.6.18(B)(8)below) are submitted concurrently, the MAC shall coordinate the review of the CAP and reconsideration request to ensure that the CAP is reviewed and a decision rendered before a reconsideration decision is rendered (if the initial determination is not resolved in its entirety by the CAP decision).

If the CAP is approved and resolves the basis for the initial determination in its entirety, the

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

If the CAP is denied:

- There are no further appeal rights; therefore, the CAP decision cannot be appealed. As a result, do not include further appeal rights for a CAP only decision.

- The MAC shall notify the provider or supplier of the denial of the CAP via the applicable CAP model letter.

- The provider or supplier may continue with the appeals process if it has filed a reconsideration request or is preparing to submit such a request and has not exceeded the timeframe in which to do so.

- The reconsideration request, if properly submitted, shall be processed.

C. Reconsideration Requests

1. Background

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

2. Requirements for Reconsideration Request Submission

a. Must contain, at a minimum, state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement;

b. Must be received within 65 calendar days from the date of the initial determination (see Section 10.6.19(A)(4) for clarification on timing). The contractor shall accept a reconsideration request via hard-copy mail, email, and/or fax;

c. Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

d. Should include all documentation and information the provider or supplier would like to be considered in reviewing the reconsideration request;

3. Receipt Acknowledgement of Reconsideration Request

Upon receipt of a properly submitted reconsideration request, the MAC shall send an email (if a valid email address is available) and hard-copy letter, to the individual that submitted the reconsideration request to acknowledge receipt of the reconsideration request using the applicable model acknowledgment letter within 14 calendar days of the date of receipt of the reconsideration request. The MAC shall send a hard-copy letter to the address listed in the reconsideration request submission or the return address listed on the reconsideration request submission envelope if no address is included on the reconsideration request letter. If no

address is listed in the reconsideration request or on the envelope, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record. In the acknowledgment letter/email (if applicable), the MAC shall advise the requesting party that the reconsideration request will be reviewed and a determination will be issued within 90 calendar days from the date of receipt of the reconsideration request. The MAC shall include a copy of the acknowledgment letter and email (if applicable) in the reconsideration file. If the reconsideration should have been submitted to CMS, the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall forward the appeal to CMS within 10 business days of the date of receipt of the reconsideration request (as specified in Section 10.6.18(A)(1)).

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

4. Reconsideration Determination

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

A proper reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. Refer to Section 10.6.18(A)(4) for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider or supplier, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the reconsideration decision being issued. The hearing officer must determine whether an error was made in the initial determination at the time the initial determination was implemented, based on all of the evidence presented. This includes:

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

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

5. Issuance of Reconsideration Determination

The hearing officer shall issue a written decision within 90 calendar days of the date of receipt of the accepted reconsideration request. The hearing officer shall email and mail a hard copy of the reconsideration decision to the provider or supplier or the individual that submitted the reconsideration request, unless an email address is unavailable or the email is

returned, then only a hard copy letter should be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the CAP decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter and include:

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

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

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's billing privileges to an approved status as of the effective date determined in the reconsidered determination or continue processing the enrollment application (as applicable).

Unless otherwise instructed by PEOG, the MAC shall only send the favorable reconsideration decision to the provider or supplier, authorized or delegated official, or its representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider or supplier of the enrollment action being taken. All enrollment updates shall be completed within 10 business days of the date the reconsideration decision was issued or the date of receipt of additional documentation, if needed.

For initial enrollments, the effective date of Medicare billing privileges is based on the date the provider or supplier is found to be in compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable retrospective billing provisions. (See Section 10.6.2 of this chapter for more information.) The MAC shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and
Ownership System (PECOS). For DMEPOS suppliers, the effective date is the date awarded by the NSC.

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

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

6. Withdrawal of Reconsideration Request

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

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

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

board governance documents, and payroll records.

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

8. Not Actionable CAPs and Reconsideration Requests

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

9. Requesting Guidance Related to CAPs and Reconsideration Requests

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

D. Further Appeal Rights for Reconsidered Determinations

1. Administrative Law Judge (ALJ) Hearing

The CMS or a provider or supplier dissatisfied with a reconsidered determination is entitled to review by an ALJ with the CRD DAB. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. To request final ALJ review, the provider or supplier must file an appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

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

(a) Clicking Register on the DAB E-File home page;
(b) Entering the information requested on the "Register New Account" form; and
(c) Clicking Register Account at the bottom of the form. If the provider or

supplier has more than one representative, each representative must register separately to use DAB E-File on his/her/its behalf.

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

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

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Pursuant to 42 C.F.R. § 405.809(a)(2), a provider or supplier may not appeal an adverse determination for a CAP, if one was made.

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

Upon receipt of a request for an ALJ hearing, an ALJ at the CRD DAB will issue a letter by certified mail to the supplier, CMS and the OGC acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference, but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The MAC shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns and/or modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider or supplier of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the settlement or ALJ decision no later than 10 business days from the date it received PEOG's specific instructions.

2. Departmental Appeals Board (DAB) Hearing

The CMS or a provider/supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

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

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the MAC of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the DAB decision no later than 10 business days from the date it received PEOG's specific instructions.

3. Judicial Review

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

E. External Monthly Reporting Requirements for CAPs and Reconsideration Requests

Using the provider enrollment appeals reporting template, the MAC shall complete all columns listed for all appeal submissions *except those submissions that are referred to CMS for processing* (CAPs and reconsideration requests). No column *shall* be left blank. *If the contractor is unable to complete all columns for a given appeal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.*

The response in column A labelled, "Initial Determination Type," *shall* be one of the following:

- **Denial:** CAP or Reconsideration Request that challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(*15*).

- **Revocation:** CAP or Reconsideration Request that challenges the revocation of Medicare billing privileges or provider/supplier number pursuant to 42 C.F.R. § 424.535(a)(1)-(*22*).

- **Effective Date:** Reconsideration request that challenges an initial determination that establishes an effective date of participation in the Medicare program, including the effective date of reactivation after

deactivation.

- ***Other:*** *CAP or reconsideration request that does not fall under the three categories listed above. If other is listed, an explanation shall be provided in the "Comments" column N and "N/A" in column G.*

The response in Column *L* labelled, "Final Decision Result," *shall* be one of the following *(If a final decision has not been issued, the column shall read as "In Process." If the appeal submission is referred to CMS for processing then the appeal should not be included on the MAC Monthly Appeals Report*

1. Not Actionable: Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Fingerprints have received a passed designation, initial determination has been reopened and revised).

2. Favorable (to provider/supplier): MAC has determined that an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status, the effective date modified, or application processing has continued.

3. Unfavorable (to provider/supplier): MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining the same.

4. Dismissed: The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)

5. Rescinded: MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.

6. Withdrawn: Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).

The response in Column M labelled, "Date Final Decision Issued," shall be "In Process" if a final decision has not been issued at the time the monthly report is sent to CMS.

The response in Column K labelled, "Date Receipt Acknowledgement Sent to Provider/Supplier/Legal Representative," shall be "Not yet sent" if a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS. The response shall be "N/A" if a receipt acknowledgement email/letter is not required for that case.
The response in Column F labelled, "MAC (Including Jurisdiction)," shall be in one of the following formats:

1. ***CGS***
2. ***FCSO***
3. ***NGS JK***
4. ***NGS J6***
5. ***Palmetto JM***
6. ***Palmetto JJ***

7. NSC

8. WPS J8

9. WPS J5

10. Noridian JE

11. Noridian JF

12. Novitas JL

13. Novitas JH

The response in Column G, "Regulatory Authority (As identified on initial determination)," shall be in the following format (the authorities will need to be modified based on the type of initial determination):

- *For Effective Date appeal: 424.520;*
- *For Denial appeal with only one authority cited in the initial determination: 424.530(a)(1-15);*
- *For Denial appeal with multiple authorities cited in the initial determination: 424.530(a)(1-15)(1-15)*
- *For Revocation appeal with only one authority cited in the initial determination: 424.535(a)(1-22)*
- *For Revocation appeal with multiple authorities cited in the initial determination: 424.535(a)(1-22)(1-22).*
- *For Other appeal: N/A with an explanation in the Comments column N.*

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall *include* the prior month's appeal submissions*, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS* (e.g., the February report shall cover all January CAPs/reconsideration requests). *All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.* If this day falls on a weekend or a holiday, the report must be submitted the following business day.

10.6.19 – Other Medicare Contractor Duties

(Rev. 10735; 04-27-21; Effective: 05-27-21; Implementation: 05-27-21)

The contractor shall adhere to all of the instructions in this chapter 10 (hereafter generally referred to as "this chapter") and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, periodic quality reviews and refresher trainings shall be performed by the contractor on a periodic basis.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS, if the provider does not exist in MCS or FISS, prior to taking action contact CMS
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application
- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested
- Report PECOS validation and production processing problems through the designated tracking system for each system release
- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855, CMS-20134 applications, opt out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR).

- Furnishing information on where to access the Form CMS-855 or CMS-20134 applications (and other general enrollment information) on-line

- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

D. Contractor Outreach to Providers

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 or CMS-20134 applications.

E. Encouraging Use of Internet-based PECOS

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855 or CMS-20134, the contractor shall encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:

- The CMS Web site at which information on Internet-based PECOS can be found and at which the paper applications can be accessed (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index?redirect=/MedicareProviderSupEnroll/).
- The contractor's address so that the applicant knows where to return the completed application.
- Any supporting documentation required for the applicant's provider/supplier type.
- Other required forms as described in sections above. Notification can be given in any manner the contractor chooses.

F. Adherence to Responsibilities Based Upon Jurisdiction

1. Audit and Claims Contractors

a. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 10.4(H)(1) of this chapter.

b. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

(i) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS). Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. If the e-mail contains any supporting documentation that contains personal health information or personally identifiable information the audit contractor shall encrypt the e-mail prior to sending.

(ii) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

c. Tie-In/Tie-Out Notices and Approval Notices

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all tie-in/tie-out notices and approval letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of tie-in/tie-out notices and approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

G. Online Presence – Web Sites

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/index.html?redirect=/medicareprovidersupenroll/ . The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Website Standards and Guidelines posted on CMS's Web site.

The CMS Provider/Supplier Enrollment Web site, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Website, and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Website that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis (specifically, no later than the 15th day of January, April, July, and October), each contractor shall review and provide updates regarding its contact information shown at URL:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf
If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's CMS PEOG Business Function Lead (BFL).

H. Document Retention

The contractor shall maintain and store all documents relating to the enrollment of a provider into the Medicare program. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence and correspondence tracking documentation, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;
- Copies of Federal, State, and/or local (city/county) business licenses, certifications and/or registrations;
- Copies of professional school degrees or certificates or evidence of qualifying course work;
- Copies of CLIA certificates and FDA mammography certificates;

- Copies of any entry found on the Medicare Exclusion Database (MED) report that leads to a provider or supplier's revocation, and;

- Copies of Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) recognition letters or certificates indicating Full or MDPP preliminary recognition.

The contractor shall dispose of the aforementioned records as described below:

1. Provider/Supplier and Durable Medical Equipment Supplier Application

a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but the billing number was subsequently revoked.

Disposition: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies
Disposition: Destroy 7 years after date of death.

2. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete.

I. Keeping Record of Activities

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as

outlined in this section 10.6.19(H). CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

The requirements in this section 10.6.19(H) are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

J. Keeping Record of Written and Telephonic Communications

(For purposes of this section 10.6.19(H), "written correspondence" includes mailed, faxed, and e-mailed correspondence.)

K. Keeping Record of Written Correspondence

The contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.

- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.

- Document all referrals to CMS, the UPIC, or the OIG

L. Keeping Record of Telephonic or Face-to-Face Contact

Telephonic or Face-to-Face Contact is hereafter referred to as "oral communication."

The contractor shall document any and all actual or attempted oral communication with the provider, any representative thereof, or any other person or entity regarding a provider. This includes, but is not limited to, the following situations:

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)

- Requesting information from the state or another contractor concerning the applicant or enrollee

- Contacting the UPIC for an update concerning a particular case

- Phone calls from the provider

- Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application

- Telephoning PEOG or the RO (e.g., the RO's survey and certification staff) and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider

- Telephoning the provider's billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated the contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write

down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be crafted and stored electronically if the contractor can provide access within 24 hours upon request.

The documentation requirements in this subsection (A) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

If an application is returned per section 10.4(H)(1) of this chapter, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

M. Documenting Verification of Data Elements

Once the contractor has completed its review of the CMS-855, CMS-20134 applications,(e.g., approved/denied application, approved change request) and Opt Out Affidavits, it shall document that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the above mentioned forms against the OIG/LEIE and the System for Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

For each person or entity that appeared on the OIG/LEIE or SAM, the contractor shall document the finding via a screen printout. In all other situations, the contractor is not encouraged to document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the verification statement is still required.

N. Release of Information

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855 and CMS-20134), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.

- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or emailed to the contractor.

- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

- The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person:

- Revalidation status (i.e., whether or not a provider/supplier has been revalidated),

- Revalidation due date,

- Revalidation approval date,

- The specific information related to a revalidation development request, and

- The date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers, without first encrypting the email.

- The contractor may not send PECOS screen printouts to the provider.

- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

O. Security

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes, in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Additionally, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

Note that these instructions are in addition to, and not in lieu of, all other instructions issued by CMS regarding security.

P. Contractor to Contractor Communications

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the "owning contractor") to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor's attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the "requesting" contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax or email (encrypted if it contains personally identifiable information) of the need to update/change/correct information in a provider's PECOS record. The notification must contain:

1. The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier; and

2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or CMS-20134).

Within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) BFL for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 or CMS-20134 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from "B."

Q. Establishment of Relationships

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

R. Ongoing Monitoring Activities

1. Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

a. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

- Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);
- Otherwise lost their medical license or have had their licenses expire.
- For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to guidance in this chapter.

- The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

S. Regarding Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in section 10.6.19(H) of this chapter, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken

T. Medicare Contractor Duties – Reporting Requirements

1. Contractor Reporting Requirements

a. Monthly Rebuttal Reporting Requirements

Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column *shall* be left blank. *If the contractor is unable to complete all columns for a given rebuttal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.*

The response in column *J* labelled, "Final Decision Result" *shall* be one of the following *(If a final decision has not yet been rendered at the time the report is due to CMS, the status shall read as "In Process.")*:

- **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 response in Column I labelled, "Date Rebuttal Determination Issued," shall be "In Process" if a rebuttal decision has not been issued at the time the rebuttal report is sent to CMS.

The response in Column H labelled, "Date Receipt Acknowledgement Sent to Provider/Supplier/Legal Representative," shall be "Not yet sent" if a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS. The response shall be "N/A" if a receipt acknowledgement email/letter is not required for that case.

The response in Column E labelled, "MAC (Including Jurisdiction)," shall be in one of the following formats:

1. ***CGS***
2. ***FCSO***
3. ***NGS JK***
4. ***NGS J6***
5. ***Palmetto JM***
6. ***Palmetto JJ***
7. ***NSC***
8. ***WPS J8***
9. ***WPS J5***
10. ***Noridian JE***

11. Noridian JF

12. Novitas JL

13. Novitas JH

The response in Column F labelled, "Regulatory Authority (As identified on initial determination)," shall be in one the following formats:

- *424.540(a)(1);*
- *424.540(a)(2);*
- *424.540(a)(3);*
- *N/A if the rebuttal was submitted in response to an enrollment action that does not afford rebuttal rights. If N/A is used in Column F, then an explanation shall be provided in Column K labelled, "Comments."*

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall *include* the prior month's rebuttal submissions*, as well as outcomes for submissions previously received that were not yet completed and reported to CMS* (e.g., the February report shall cover all January rebuttals). *All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.* If this day falls on a weekend or a holiday, the report shall be submitted the following business day.