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Provider Enrollment Appeals Procedure

MLN Matters Number: MM11210 | Related Change Request (CR) Number: 11210

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Related CR Transmittal Number: R936PI | Implementation Date: May 1, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11210 updates the provider enrollment policy that outlines corrective action plans (CAPs) and reconsideration requests. The CR also updates applicable model letters, including initial determinations, the MACs use to advise providers and suppliers of their review rights. Please make sure your billing staffs are aware of these updates.

BACKGROUND

The official instruction attached to CR 11210 provides a list of revised and new sections of the Centers for Medicare & Medicaid Services (CMS) Publication 100-08, the Medicare Program Integrity Manual, Chapter 15, Sections 24 and 25 that address CAPs, reconsideration requests, and model letters MACs use advising enrollees of their review rights. You may review the complete text of each new or revised appeals enrollment procedure, including model letters, in the official CR 11210 instruction.

You may submit a CAP in response to the denial of an enrollment application under 42 C.F.R. Section 424.530(a)(1) or the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration. If your enrollment application was denied or your Medicare billing privileges revoked under authorities other than 42 C.F.R. 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those denial and/or revocation bases.

The CAP is an opportunity for the provider or supplier to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges. When submitting a CAP, it must:

1. Be received in writing within 35 calendar days of the date of the MAC's denial letter.

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

You may also request a reconsideration of a denial or revocation of billing privileges. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

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

Providers and suppliers may:

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

Note: If denied under 42 C.F.R. § 424.530(a)(2) or revoked under 42 C.F.R. § 424.535(a)(2), you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration isn't timely requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights is available in 42 CFR Part 498 at https://ecfr.io/Title-42/pt42.5.498.

ADDITIONAL INFORMATION

The official instruction, CR 11210, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r936PI.pdf. This transmittal includes the entire revision to the Medicare Program Integrity Manual.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
January 31, 2020	Initial article released.

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