CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 95 **Date: JANUARY 14, 2005**

CHANGE REQUEST 3601

SUBJECT: Change in Provider Enrollment Appeals Process

I. SUMMARY OF CHANGES: Revisions to Chapter 10, Section 19 – Administrative Appeals of Medicare Enrollment and Billing Number denials and revocations to implement MMA Section 936(a)(2).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: December 8, 2004
IMPLEMENTATION DATE: February 14, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/19/Administrative Appeals

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

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

Attachment – One-Time Notification

Pub. 100-08	Transmittal: 95	Date: January 14, 2005	Change Request 3601

SUBJECT: Change in Provider Enrollment Appeals Process

I. GENERAL INFORMATION

A. Background: Section 936(a) (2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Secretary to establish an appeals process for a provider and supplier whose application for enrollment or renewal of enrollment has been denied. Under this provision, providers and suppliers would have the right to a hearing and judicial review. We interpret this statutory provision as also applying to actions to revoke a provider or supplier's enrollment. Section 936(b)(3) of the MMA provides that these hearing rights must apply to denials occurring on or after such date as the Secretary specifies, and no later than 1 year after the date of enactment of the MMA, which was December 8, 2003.

B. Policy: To ensure that the new mandated process is followed, any denial or revocation with a decision date of December 8, 2004 or later, where the next level of appeal would have been to the CMS reviewing official shall now be sent to the Administrative Law Judge level, located at:

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

In addition, contractor hearing officers shall change their decision letters to the providers/suppliers whose application for enrollment has been denied or whose billing number has been revoked and provide the new address to send their denial or revocation ALJ hearing requests. They shall include in their decision an instruction to the provider/supplier that if they appeal to the ALJ, the provider/supplier must include their name, provider/supplier number and/or their IRS TIN/EIN, and a copy of the carrier hearing officer decision.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3601.1	Contractor hearing officers shall change their decision letters to include a new address for requesting ALJ hearing and what information to submit with the appeal.	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: December 8, 2004 **Implementation Date:** February 14, 2005 **Pre-Implementation Contact(s):** Elizabeth Horn, x60973; EHorn@cms.hhs.gov **Post-Implementation Contact(s):** Elizabeth Horn, x60973; EHorn@cms.hhs.gov	**Medicare contractors shall implement these instructions within their current operating budgets.**

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19 - Administrative Appeals

(Rev. 95, Issued: 01-14-05, Effective: 12-08-04, Implementation: 02-14-05)

A. Contractors

Process for *p*hysicians, *n*on-physician *p*ractitioners, DMEPOS suppliers and *e*ntities whose Medicare *e*nrollment *i*s *d*enied or *w*hose *b*illing *n*umber *i*s *r*evoked.

A physician, non-physician practitioner, DMEPOS supplier or other entity, whose Medicare enrollment is denied or whose Medicare billing privilege is revoked, can request an appeal of that decision. This appeal procedure ensures that a physician, non-physician practitioner, DMEPOS supplier or entity that is not entitled to appeal rights under 42 CFR 498 receives a fair opportunity to be heard.

The appeals process can be found at 42 CFR 405.874. The administrative appeals process includes the right to a Medicare *contractor* hearing before a hearing officer who was not involved with the original *contractor* determination, the right to seek a *hearing* before an *Administrative Law Judge (ALJ), the right to review of the ALJ decision by the Departmental Appeals Board, and the right to judicial review*.

If a Medicare *contractor* reviews the application and finds that a physician, non-physician practitioner, DMEPOS *supplier*, or entity does not meet one or more of the requirements, the Medicare *contractor* denies the application and sends a denial letter explaining the reason for the denial to the physician, non-physician practitioner, DMEPOS supplier or entity. The letter explains the procedures for requesting a Medicare *contractor* hearing.

Similarly, when a Medicare *contractor* discovers that a physician, non-physician practitioner, DMEPOS supplier or entity no longer meets one of the requirements for a billing number, the physician's, non-physician practitioner's, DMEPOS supplier or entity's billing number is revoked. The *contractor* sends the physician, non-physician practitioner, DMEPOS supplier or entity a letter that explains that the billing number is revoked 15 days from the date the notice is mailed *and* stating why the billing number is being revoked, and informs the physician, non-physician practitioner, DMEPOS supplier or entity of the procedures for requesting a *contractor* hearing.

The physician, non-physician practitioner, DMEPOS supplier or entity *may* seek review of the *denial or revocation* determination by filing a request for a *contractor* hearing. *The* physician, non-physician practitioner, DMEPOS supplier or entity or the *contractor* may *appeal the contractor hearing officer decision by requesting an ALJ hearing*. An initial contractor determination *or* a decision of a contractor hearing officer may be reopened by the contractor or hearing officer in accordance with the procedures set forth at 42 CFR 405.84l and 405.842.

If, instead of filing or completing an appeal, a physician, non-physician practitioner, DMEPOS supplier or entity completes a corrective action plan and provides sufficient

evidence to the *contractor* that it has complied fully with the Medicare requirements, the contractor may reinstate the physician's, non-physician practitioner's, DMEPOS supplier or entity's billing number. The contractor may pay for services furnished on or after the effective date of the reinstatement.

B. Contractor Hearing

A physician, non-physician practitioner, DMEPOS supplier or entity that wishes to request a contractor hearing must file its request with the Medicare contractor within *90* days *after the postmark date* of the initial determination letter to be considered timely filed. The date the *request* is received by the contractor is treated as the date of filing. Failure to timely request a contractor hearing is deemed a waiver of all rights to further administrative review. The request may be signed by the physician, non-physician practitioner, or any responsible official within the entity. *For DMEPOS suppliers, the request must be signed by the authorized representative, owner or partner.*

If a timely request for a contractor hearing is made, a contractor hearing officer, not involved in the original determination to disallow a physician, non-physician practitioner, DMEPOS supplier or entity enrollment application, or to revoke a current billing number, must hold a hearing within 60 days of receipt of the appeal request, or later if requested by the physician, non-physician practitioner, DMEPOS supplier or entity. The physician, non-physician practitioner, DMEPOS *supplier*, entity or the contractor may offer new evidence. The burden of persuasion is on the physician, non-physician practitioner, *DMEPOS supplier* or entity to show that its enrollment application was incorrectly disallowed or that the revocation of its billing number was incorrect. The contractor hearing officer's determination is based upon the information presented. The hearing is a thorough, independent review of the contractor's initial determination and the entire body of evidence, including any new information submitted. The contractor hearing can be held in person or by telephone at the physician's, non-physician practitioners, DMEPOS supplier or entity's request.

The hearing officer issues a written decision as soon as practicable after the hearing and forwards the decision by certified mail to CMS, the *contractor*, and the physician, non-physician practitioner, DMEPOS supplier or entity. The decision includes (i) information about the *contractor's*, physician's, non-physician practitioner's, DMEPOS supplier or entity's further right to appeal; (ii) the address to which the written appeal must be mailed; (iii) the date by which the appeal must be filed; *and, (iv) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the contractor hearing officer decision.)*

A physician, non-physician practitioner, DMEPOS *supplier*, contractor or entity may appeal the hearing officer's decision *to the ALJ*. *Such appeal must be filed within 60 days from receipt* of the hearing officer's decision. Failure to timely request the *ALJ hearing* is deemed a waiver of all rights to further administrative review. A contractor hearing officer's Partial or complete reversal of a *contractor's* initial determination is not

implemented pending the contractor's decision to appeal the reversal to *the ALJ*, unless the contractor, in its sole discretion, and without prejudice to its right to appeal, decides to implement the reversal pending an appeal. The contractor implements a reversal if it decides not to appeal a reversal to *the ALJ*, or the time to appeal expires. A contractor may implement a contractor hearing officer's *p*artial reversal even if the physician, non-physician practitioner, DMEPOS supplier or entity has appealed the *p*artial reversal to *the ALJ*, or the time for the physician, non-physician practitioner, DMEPOS supplier or entity to file an appeal has not expired.

C. Claims Submitted Following Revocation

If a contractor finds that payment to an organization or other entity is precluded under the reassignment statute and regulations, and the billing number is revoked, subsequent claims submitted by the reassignee following revocation will be rejected. The physician or non-physician practitioner that furnished the health care service can bill the Medicare program for payment in accordance with the applicable rules for submitting claims.

NOTE: CMS may take the appropriate steps to collect Medicare overpayments or pursue other appropriate legal remedies.

D. *Administrative Law Judge (ALJ) Hearing*

If a timely request for *an ALJ hearing following the contractor hearing officer's decision is made, an ALJ hearing is held following procedures found at 42 CFR Part 498, Subpart D – Hearings. The request for ALJ hearing must be filed in writing within 60 days from receipt of the notice of the contractor hearing decision. Requests should be sent to:*

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

In addition, at the contractor hearing officer level, the hearing officer decision letter shall provide the above address for where to send a request for ALJ hearing. The hearing officer decision shall also instruct the appellant that if they submit an appeal to the ALJ it must include their name, provider/supplier number (if applicable), their IRS TIN/EIN, and a copy of the contractor hearing officer decision.

Appeal rights for prospective and existing providers can be found at 42 CFR §498 of the Medicare regulations. The regulation explains the appeal rights for certain prospective and existing providers following determinations by CMS as to whether such entities meet and/or continue to meet the requirements for enrollment in the Medicare program.

The contractor must assist the RO in the issuance of denials, and must provide and review information as requested by the RO concerning appeals of issued denials.