CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13085	**Date: March 13, 2025**
	Change Request 13840

SUBJECT: Update to Provider Enrollment Appeals and Rebuttals Processing Instructions and Model Letters

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the Medicare Administrative Contractors to process Medicare provider enrollment appeals related to individual physician and practitioner opt-outs in Chapter 10 of Publication (Pub.) 100-08 (Medicare Program Integrity Manual or MPIM). This CR will also update other provider enrollment appeal and rebuttals processing instructions and model letters, as well as opt-out and deactivation model letters.

EFFECTIVE DATE: May 13, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 13, 2025

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	10/10.4.8.1/Deactivation Rebuttals
R	10/10.4.9.1/Stay of Enrollment Rebuttals
R	10/10.6.18/Appeals Process
R	10/10.7.11/Reconsideration Request Model Letters
R	10/10.7.12/Deactivation Model Letters
R	10/10.7.13/Deactivation Rebuttal Model Letters
R	10/10.7.14/Model Opt-out Letters
R	10/10.7.20/Stay of Enrollment Letters

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: 13085	Date: March 13, 2025	Change Request: 13840

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II. GENERAL INFORMATION

A. Background: Chapter 10 of Pub. 100-08 outlines policies related to provider enrollment appeals and rebuttals. This CR provides updated instructions and model letters on how to process provider enrollment appeals and rebuttals.

B. Policy: This CR does not involve any legislative or regulatory policies.

III. 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	
13840.1	The contractor shall follow the instructions in this CR pertaining to appeals related to opt-out affidavits.	X	X	X						
13840.2	The contractor shall observe the changes to and additions in	X	X	X						NPEAST, NPWEST

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Sections 10.4, 10.6, and 10.7 in Chapter 10 of Pub. 100-08.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

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

VII. 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: 3

Medicare Program Integrity Manual

Chapter 10 – Medicare Enrollment

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(Rev. 13085; Issued: 03-13-25)

Transmittals for Chapter 10

10.4.8.1 – Deactivation Rebuttals

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

A. Background

Pursuant to 42 CFR § 424.546, a provider/supplier whose Medicare billing privileges have been deactivated under 42 CFR § 424.540(a) may file a rebuttal. A rebuttal is an opportunity for the provider/supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per enrollment deactivation. Additional rebuttal requests submitted for the same deactivated enrollment for which a rebuttal has already been received shall be dismissed.

If an application is received for a deactivated provider/supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application consistent with current processing instructions. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless: (1) the submitted application is required to reactivate the provider/supplier's enrollment; or (2) if there are new changes being reported. If an application (1) is received while a rebuttal submission is pending, (2) is approved prior to the issuance of a rebuttal determination, and (3) results in the provider's or supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

B. Notification Letters for Deactivations

If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities in 42 C.F.R. § 424.540, the contractor shall deactivate the provider/supplier unless another CMS directive applies. If a revocation authority is applicable, the contractor shall follow the instructions in sections 10.4.7 and 10.4.8 et seq. of this chapter in lieu of deactivating the enrollment. If no revocation authority applies, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall send a notification letter for every deactivated enrollment. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider's or supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.

C. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Pursuant to 42 C.F.R. § 424.546(b), to be accepted and processed, the rebuttal submission must:

(1) Be in writing;

(2) Specify the facts or issues concerning the rebuttal with which the provider or supplier disagrees, and the reasons for disagreement;

(3) Include all documentation the provider or supplier wants CMS to consider in its review of the deactivation;

(4) Be submitted in the form of a letter that is signed and dated by the individual supplier (if enrolled as an individual physician or nonphysician practitioner), the authorized official or delegated official (as those terms are defined in 42 C.F.R. § 424.502), or a legal representative (as defined in 42 C.F.R. § 498.10);

- If the legal representative is an attorney, the attorney must include a statement that he/she/they have the authority to represent the provider or supplier; this statement is sufficient to constitute notice of such authority.
- If the legal representative is not an attorney, the provider or supplier must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the individual supplier, the authorized official or delegated official, or a legal representative.
- Authorized or delegated officials for groups cannot sign and submit a rebuttal 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/their behalf.
- Signatures may be original or electronic. Valid signatures include handwriting (wet) signatures in ink and digital/electronic signatures. Digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) and email signatures shall be accepted. Contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures.

(5) Be received by the contractor within 15 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax;

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

If a rebuttal submission: (1) is not appropriately signed and no response is received to the development request (if applicable); (2) is untimely (as described above); (3) does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement and no response is received to the development request; or (4) is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter. For those rebuttal submissions that are improperly signed and/or do not specify the facts or issue with which the provider or supplier disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider/supplier requesting a proper signature and/or clarification on the facts or issues with which the provider or supplier disagrees and the reasons for disagreement using the applicable Rebuttal Development Model Letter. Sending the development letter via fax is optional. The contractor shall grant an additional 15-calendar days from the date of the development request letter for the provider or supplier to submit an acceptable rebuttal submission. If no response is received or the rebuttal submission is still deficient after the development request and the 15-calendar day timeframe has expired, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter.

The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the 15 calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the

provider/supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

If the 15th calendar day from the date on the deactivation notice falls on a weekend or federally-recognized holiday, the rebuttal shall be accepted as timely if the contractor received it by the next business day.

It is the provider's or supplier's responsibility to timely update his/her/their/its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to, its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar-days of receipt of the accepted rebuttal request using the Rebuttal Acknowledgment Model Letter, including a rebuttal tracking number and the provider's or supplier's NPI. The acknowledgement letter shall also be sent via email if a valid email address is available (either in the enrollment record or rebuttal submission). It is optional for the contractor to send the acknowledgement letter via fax if a valid fax number is available. If a rebuttal determination is issued within 10 calendar-days of the date of receipt of the rebuttal submission then the contractor is not required to issue a receipt acknowledgement letter.

The contractor shall process all accepted rebuttal submissions within 30 calendar-days of the date of receipt. If, while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued. If a provider or supplier submits a written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination then the contractor shall issue a letter using the applicable Rebuttal Withdrawn Model Letter and no rebuttal determination shall be issued.

The contractor's review of the rebuttal submission shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider/supplier shall be considered by the contractor in its review.

4. Reason-Specific Instructions

a. § 424.540(a)(1)

For deactivations under § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the 6-month period preceding the date of deactivation, starting with the first day of the first month 6 months prior to the date of deactivation. If it is confirmed that billing occurred within 6 months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the 6-

month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination. Consider the following illustration:

EXAMPLE: Dr. Awesome has been enrolled in Medicare since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2019. Dr. Awesome's enrollment is deactivated, under 42 C.F.R. § 424.540(a)(1), effective January 1, 2020. Dr. Awesome timely submits a rebuttal in response to the deactivation. Upon review by the contractor, it is confirmed that Dr. Awesome had not submitted claims since January 2019. Therefore, an unfavorable rebuttal determination would therefore be appropriate in this scenario, for the deactivation was appropriate.

b. § 424.540(a)(2)

For deactivations under § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within the required timeframe. The required timeframe to submit updated information is described at 42 C.F.R. §§ 424.550, 410.33(g)(2), 424.57(c)(2), and 424.516(d). If information was submitted properly and timely, the contractor shall approve the rebuttal submission, issue a favorable rebuttal determination, and reinstate the provider 's or supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request and issue an unfavorable rebuttal determination, as the deactivation was appropriate. In making this determination, the contractor shall consider, at minimum, the following.

- Whether the deactivation was implemented after the required timeframe to report a change of enrollment information elapsed;
- Whether the letter notifying the provider/supplier of the deactivation was sent to the correct address as instructed in section 10.7 et seq. of this chapter; and
- Whether the enrollment changes were received in an enrollment application that was processed to completion within the required timeframe.

Consider the following illustration:

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

In this scenario, the deactivation was correctly implemented after 30 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 30 days of the change of enrollment information. Though the contractor received an application within 30 days of the change of enrollment information, that application was not processed to completion. Thus, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was appropriately implemented.

c. § 424.540(a)(3)

For deactivations under § 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following:

- Whether the deactivation was implemented after 90 days of the revalidation request.
- Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 10.7 of this chapter.
- Whether a revalidation application was timely received and was processed to completion.

Consider the following scenario:

EXAMPLE: On January 1, 2022, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2022. The contractor receives a revalidation application from Dr. Great on March 1, 2022. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2022 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2022 under 42 C.F.R. § 424.540(a)(3). Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Accordingly, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was appropriately implemented.

d. § 424.540(a)(4) and (5)

For deactivations under § 424.540(a)(4), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier was, in fact, compliant with all enrollment requirements at the time of the deactivation

For deactivations under § 424.540(a)(5), the contractor shall review all submitted documentation and internal records to determine whether the provider's or supplier's practice location was operational or otherwise valid at the time of the deactivation.

If the provider or supplier was indeed compliant or operational at the time of the deactivation, the contractor shall approve the rebuttal request and reinstate the provider's or supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required.

e. § 424.540(a)(6)-(8)

Although rebuttals under § 424.540(a)(6)-(8) these three deactivation grounds are uncommon, the provider or supplier may submit one. Upon receipt of a rebuttal submission, the contractor shall review all submitted documentation and internal records to determine whether the deactivation pursuant to the regulatory basis in question was appropriate. If it was not, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or

approval of the rebuttal request is not required. If the rebuttal was not submitted properly and timely, the contractor shall dismiss the rebuttal request.

D. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate Model Rebuttal Decision Letter. If the contractor is unable to render a determination, the contactor shall use the appropriate Model Letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent (1) via hard-copy mail to the return address on the rebuttal submission; (2) via hard-copy mail to the correspondence mailing address on the enrollment records (if different from return address on rebuttal submission); and (3) by e-mail if a valid e-mail address is available (submitted as part of the rebuttal submission and/or listed in the enrollment record correspondence mailing address). The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider's or supplier's Medicare billing privileges within 10 business days of the date on the favorable determination letter. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contactor issues a rebuttal determination unfavorable to the provider or supplier, the provider's or supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If a rebuttal determination overturns the deactivation, the contractor shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that has not been processed to completion, unless the application is needed to reactivate the enrollment or if there are new changes being reported. If the contractor confirms that the application is not needed and that no new changes are being reported, the contractor shall use the following return reason in the Returned Application Model Letter found at 10.7.7.A of this chapter in response to the scenario described above: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed."

If additional information/documentation is needed prior to reinstating the provider or supplier as part of a favorable rebuttal determination (e.g., deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in its rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider/supplier to again request the additional information/documentation within 10 calendar days of not receiving a response.

If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

E. No Further Review

Pursuant to 42 C.F.R. § 424.546(f), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.

F. External Monthly Reporting for Rebuttals

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all rebuttal submissions received and processed by the contractor. No column shall be left blank (except Column K, as described below). 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 reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g. 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's rebuttal 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 rebuttals).

IMPORTANT: All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.

- **Column A:** The response in Column A labelled, "Provider/Supplier Name" *shall be the legal business name of the provider/supplier*, exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation). *This column shall not be blank.*

- **Column B:** The response in Column B labelled, "NPI" shall be the provider's or supplier's NPI *number*. *If a provider/supplier has multiple NPIs, each shall be separated with a semicolon followed by a space (e.g. "1234567890; 1123456789"). This column shall not be blank.*

- **Column C:** The response in Column C labelled, "EID" shall be the provider's or supplier's *PECOS enrollment identification number (EID) as it appears in PECOS. On the rare occasion that no EID is available, the contractor shall enter "N/A". This column shall not be blank.*

- **Column D:** The response in Column D labelled, "PTAN(s)" shall *be the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)), or other Medicare ID number. If the provider/supplier has not yet been assigned a PTAN or Medicare ID, the contractor shall enter "N/A". This column shall not be blank.*

- **Column E:** The response in Column E labelled, "Contractor," shall be in one of the following formats*, as appropriate*. *This column shall not be blank.* No other formats are acceptable.

    - ***CGS***
    - ***FCSO***
    - ***NGS JK***
    - ***NGS J6***
    - ***Palmetto JM***
    - ***Palmetto JJ***
    - ***NSC***
    - ***WPS J8***
    - ***WPS J5***
    - ***Noridian JE***
    - ***Noridian JF***

- ***Novitas JL***
- ***Novitas JH***
- ***NPEast***
- ***NPWest***

- **Column F:** The response in Column F labelled, "Regulatory Authority," shall be in the following format. If the response is "Other (see Comments)" the Contractors shall use Column K to provide explanatory notes (e.g. when a rebuttal is submitted in response to an enrollment action that does not afford rebuttal rights, describe the enrollment action in Column K). *This column shall not be blank.* No other formats are acceptable:

  - 424.540(a)(1)
  - 424.540(a)(2)
  - 424.540(a)(3)
  - 424.540(a)(4)
  - 424.540(a)(5)
  - 424.540(a)(6)
  - 424.540(a)(7)
  - 424.540(a)(8)
  - Other (see Comments)

- **Column G:** The response in Column G labelled, "Date Received" shall be the date on which the Contractor received the rebuttal. The date shall be formatted as mm/dd/yyyy (e.g. 10/25/2021)*; no other formats are acceptable. This column shall not be blank.*

- **Column H:** The response in Column H labelled, "Date Receipt Acknowledgement Sent," shall be *one of the following:*

  - ***[mm]/[dd]/[yyyy]***
    The date the receipt acknowledgement email/letter was sent to the provider/supplier or the representative, in "mm/dd/yyyy" format. No other date formats are acceptable.

  - ***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.

  - ***N/A***
    If a receipt acknowledgement email/letter is not required for that case (i.e., rebuttal determination is issued within 10-calendar days of the date of receipt of the rebuttal submission).

- **Column I:** The response in Column I labelled, "Date *Final Decision* Issued" shall be the date on which the Contractor issues the rebuttal determination. The date shall be formatted as mm/dd/yyyy (e.g. 09/19/2019). If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response. *No other formats are acceptable. This column shall not be blank.*

- **Column J:** The response in Column J labelled, "Final Decision Result," shall be one of the following. No other formats are acceptable.

  - **Not Actionable**

Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved (e.g. deactivation was rescinded).

- **Favorable**
  Contractor has determined that an error was made in the implementation of the deactivation. Therefore, the *deactivation* was overturned and the enrollment record has been placed in approved status *with no gap in billing privileges*.

- **Unfavorable**
  Contractor upholds the deactivation resulting in the enrollment remaining deactivated.

- **Dismissed**
  The rebuttal submission does not meet the rebuttal requirements (e.g. missing proper signature and did not timely respond to development request).

- **Withdrawn**
  Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledged the withdrawal.

- **In Process**
  A final decision has not been issued. The Contractor is still processing the submission.

- **Column K:** The response in Column K labelled, "Comments," shall include any information related to the deactivation, rebuttal submission, or rebuttal determination that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.4.9.1 – Stay of Enrollment Rebuttals

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

Note that the MAC will handle all non-DMEPOS supplier stay rebuttals consistent with the instructions in this section 10.4.9.1 and all other CMS guidance. *DMEPOS supplier stay rebuttals will be handled by the PEOG Division of Provider Enrollment Appeals. All stay of enrollment rebuttals for DMEPOS supplier shall be forwarded to providerenrollmentappeals@cms.hhs.gov within 5 days of receipt.*

A. Background

Pursuant to 42 CFR § 424.541(b), a provider/supplier (hereafter "provider") under a stay of enrollment may file a rebuttal. A rebuttal is an opportunity for the provider to demonstrate that it met all applicable enrollment requirements and that the stay should not have been imposed. Only one rebuttal request may be submitted per enrollment stay. Additional rebuttal requests submitted for the same stay for which a rebuttal has already been received shall be dismissed.

If the applicable CMS form (ACF) (see section 10.4.9) is received for a "stayed" provider while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the ACF consistent with current instructions.

CMS's Division of Provider Enrollment Appeals (DPEA) will handle all stay of enrollment rebuttals for DMEPOS suppliers. Stay of enrollment letters for DMEPOS suppliers shall instruct suppliers to files rebuttals with CMS. The Contractor shall forward all stay of

enrollment rebuttals for DMEPOS suppliers to ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days of receipt. The Contractor shall not process the rebuttal if it is required to be forwarded to CMS.

B. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Pursuant to 42 C.F.R. § 424.541(b), to be accepted and processed, the rebuttal submission must—

(1) Be in writing;

(2) Specify the facts or issues concerning the rebuttal with which the provider disagrees, and the reasons for disagreement;

(3) Include all documentation the provider wants CMS to consider in its review of the stay;

(4) Be submitted in the form of a letter that is signed and dated by the individual supplier (if enrolled as an individual physician or nonphysician practitioner), the authorized official or delegated official (as those terms are defined in 42 *C.F.R.* § 424.502), or a legal representative (as defined in 42 C.F.R. § 498.10).

- If the legal representative is an attorney, the attorney must include a statement that he/she/they have the authority to represent the provider; this statement is sufficient to constitute notice of such authority.
- If the legal representative is not an attorney, the provider must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the individual supplier, the authorized official or delegated official, or a legal representative.
- Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider without the provider submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.
- Signatures may be original or electronic. Valid signatures include handwriting (wet) signatures in ink and digital/electronic signatures. Digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) and email signatures shall be accepted. Contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures.

(5) Be received by the contractor within 15 calendar days from the date of the stay notification letter to the provider. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax.

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

If a rebuttal submission--(1) Is not appropriately signed and no response is received to the development request (if applicable); (2) Is untimely (as described above); (3) Does not specify the facts or issues with which the provider disagrees and the reasons for disagreement

and no response is received to the development request; or (4) Is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable rebuttal dismissal model letter. (*The contractor shall use the applicable model letter in section 10.7.20 of this chapter. If the applicable model letter does not exist, the contractor should use* the same rebuttal dismissal letters applicable to deactivation letters, modifying them to apply to the stay situation.) For those rebuttal submissions that are improperly signed and/or do not specify the facts or issues with which the provider disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider requesting a proper signature and/or clarification on the facts or issues with which the provider disagrees and the reasons for disagreement using the applicable rebuttal development model letter. Sending the development letter via fax is optional. The contractor shall grant an additional 15-calendar days from the date of the development request letter for the provider to submit an acceptable rebuttal submission. If no response is received or the rebuttal submission is still deficient after the development request and the 15-calendar day timeframe has expired, the contractor shall dismiss the rebuttal submission using the applicable rebuttal dismissal model letter.

The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the 15 calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

If the 15th calendar day from the date of the stay notification letter falls on a weekend or federally-recognized holiday, the rebuttal shall be accepted as timely if the contractor received it by the next business day.

It is the provider's responsibility to timely update their enrollment record to reflect any changes to their enrollment information including, but not limited to, their correspondence address. Failure to timely update a correspondence address or other addresses included in their Medicare enrollment record does not constitute an "in fact" showing that the stay notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar-days of receipt of the accepted rebuttal request using the rebuttal acknowledgment model letter, including a rebuttal tracking number and the provider's NPI. The acknowledgement letter shall also be sent via email if a valid email address is available (either in the enrollment record or rebuttal submission). It is optional for the contractor to send the acknowledgement letter via fax if a valid fax number is available. If a rebuttal determination is issued within 10 calendar-days of the date of receipt of the rebuttal submission, the contractor is not required to issue a receipt acknowledgement letter.

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

rebuttal submission prior to the issuance of a rebuttal determination, the contractor shall issue a letter using the applicable rebuttal withdrawn model letter and no rebuttal determination shall be issued.

All materials received from the provider shall be considered by the contractor in its review.

4. Reason-Specific Instructions

As explained in section 10.4.9, CMS may impose a stay if the following two requirements are met:

- The provider is non-compliant with at least one enrollment requirement in Title 42; **and**

- The provider can remedy the non-compliance via the submission of, as applicable to the situation, a Form CMS-855, Form CMS-20134, or Form CMS-588 change of information or revalidation application (hereafter collectively referenced as "the applicable CMS form" or "ACF".)

In its review, therefore, the contractor shall, as a general principle, ascertain whether the provider (1) was indeed non-compliant and (2) can remedy the non-compliance by submitting an ACF. The contractor can review section 10.4.8.1(C)(4) (which addresses deactivation rebuttals) and apply the same basic principles discussed in those illustrations to their factually corresponding stay rebuttal situations.

Note that for stay rebuttals other than that discussed in Example (ii)(A) below, the contractor may need additional information (beyond that referenced in section 10.4.9(A)) regarding PEOG's decision to impose a stay. In such cases, the contractor shall contact ProviderEnrollmentRevocations@cms.hhs.gov and clearly outline the requested data. The 30-day timeframe for processing the rebuttal stops between the times the contractor sends the request and receives the information from PEOG.

C. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contactor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent (1) via hard-copy mail to the return address on the rebuttal submission; (2) via hard-copy mail to the correspondence mailing address on the enrollment records (if different from return address on rebuttal submission); and (3) by e-mail if a valid e-mail address is available (submitted as part of the rebuttal submission and/or listed in the enrollment record correspondence mailing address). The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider, it shall make the necessary modification(s) to the provider's enrollment within 5 calendar days of the date of the favorable determination letter. This will involve a rescission of the stay regardless of whether the stay has already been lifted or is still in effect. If the contractor confirms that the ACF is not needed and that no new changes are being reported, the contractor shall use the following return reason in the returned application model letter found in section 10.7.7 of this chapter: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed." If new changes were being reported as part of the ACF, the contractor shall process those changes.

If the contactor issues a rebuttal determination unfavorable to the provider, the stay (irrespective of whether it has been lifted) remains intact. Hence, if a stay existed from March 1 to March 10 and the stay was upheld on April 1, the record shall still reflect that the provider was under a stay between March 1 – 10.

D. No Further Review

Pursuant to § 424.541(b)(6), a determination made regarding a stay rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.

E. External Monthly Reporting for Stay Rebuttals

(This data shall be reported in a template separate from that concerning deactivation rebuttals per section 10.4.8.1. *of this chapter.*)

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all stay rebuttal submissions received and processed by the contractor. No column shall be left blank (except Column K, as described below and as applicable). 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 reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g., 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's rebuttal 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 rebuttals).

IMPORTANT: All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.

- **Column A:** The response in Column A labelled, "Provider/Supplier Name" *shall be the legal business name of the provider/supplier, exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation). This column shall not be blank.*

- **Column B:** The response in Column B labelled "NPI" shall be the provider's or supplier's NPI. *If a provider/supplier has multiple NPIs, each shall be separated with a semicolon followed by a space (e.g. "1234567890; 1123456789"). This column shall not be blank.*

- **Column C:** The response in Column C labelled, "EID" shall be the provider's or supplier's EID *PECOS enrollment identification number (EID) as it appears in PECOS. On the rare occasion that no EID is available, the contractor shall enter "N/A". This column shall not be blank.*

- **Column D:** The response in Column D labelled, "PTAN(s)" shall *be the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)), or other Medicare ID number. If the provider/supplier has not yet been assigned a PTAN or Medicare ID, the contractor shall enter "N/A". This column shall not be blank.*

- **Column E:** The response in Column E labelled, "Contractor," shall be in one of the

following formats*, as appropriate*. *This column shall not be blank.* No other formats are acceptable.

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

- **Column F:** *The response in Column F labelled "Non-Compliance" shall* briefly describe the non-compliance that led to the stay (e.g., revalidation non-response). *This column shall not be blank.*

- **Column G:** The response in Column G labelled, "Date Received" shall be the date on which the Contractor received the rebuttal. The date shall be formatted as mm/dd/yyyy (e.g. 10/25/2021)*; no other formats are acceptable. This column shall not be blank.*

- **Column H:** The response in Column H labelled, "Date Receipt Acknowledgement Sent," shall be *one of the following:*

  - ***[mm]/[dd]/[yyyy]***
    The date the receipt acknowledgement email/letter was sent to the provider/supplier or the representative, in "mm/dd/yyyy" format. No other date formats are acceptable.

  - ***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.

  - ***N/A***
    If a receipt acknowledgement email/letter is not required for that case (i.e., rebuttal determination is issued within 10-calendar days of the date of receipt of the rebuttal submission).

- **Column I:** The response in Column I labelled, "Date *Final Decision* Issued" shall be the date on which the Contractor issues the rebuttal determination. The date shall be formatted as mm/dd/yyyy (e.g. 09/19/2019). If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response. *No other formats are acceptable. This column shall not be blank.*

- **Column J:** The response in Column J labelled, "Final Decision Result," shall be one of the following. No other formats are acceptable.

- **Not Actionable**
  Rebuttal is no longer actionable (moot) because the basis for the stay has been resolved (e.g., CMS rescinded the stay).

- **Favorable**
  Contractor has determined that an error was made in the implementation of the stay. Therefore, the initial determination was overturned and the stay has been *removed*.

- **Unfavorable**
  Contractor upholds the initial stay determination.

- **Dismissed**
  The rebuttal submission does not meet the rebuttal submission requirements (e.g. missing proper signature and did not timely respond to development request).

- **Withdrawn**
  Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledged the withdrawal.

- **In Process**
  A final decision has not been issued. The contractor is still processing the submission.

- **Column K:** The response in Column K labelled, "Comments," shall include any information related to the stay, rebuttal submission, or rebuttal determination that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.6.18 – Appeals Process

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

This section contains instructions for how the Medicare Administrative Contractors (hereinafter, "MACs" or "Contractors") shall process provider enrollment corrective action plans (hereinafter, "CAPs") and reconsideration requests. CAPs and reconsideration requests are collectively referred to as "appeals".

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

1. Background

This review process of initial determinations applies to all providers/suppliers and ensures that all current and prospective providers/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/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/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; (3) the effective date of participation in the Medicare program*; and (4) whether a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out.*

Any 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) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The 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/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/suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider/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 § 424.535(a)(1). While CAPs may only be submitted in response to a denial under § 424.530(a)(1) or a revocation under § 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/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 (as defined in Section 10.4.*7.4(D)* of this chapter)*, including those regarding effective dates, denials, and revocations*;

- CAPs and reconsideration requests for Independent Diagnostic Testing Facilities *(IDTFs)*;

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

- CAPs and reconsideration requests for Opioid T*reatment* 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), (14), (15), and (17)*;*

- 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), (15), (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 § 424.535(e);

- *CAPs and r*econsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);

- *CAPs and r*econsideration requests challenging the addition of years to an existing re-enrollment bar;

- *CAPs and r*econsideration 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; and

- Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in *42 C.F.R.* § 422.2 or § 423.100.

(NOTE: As indicated in section 10.4.7.4(D) of this chapter – and notwithstanding any other instruction to the contrary in this chapter (including in this section 10.6.18(A)(1)) -- the MAC shall make all reconsideration determinations for denials under § 424.530(a)(18) and revocations under § 424.535(a)(23).)

If the provider/supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or § 424.535(a)(1), (5), (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/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/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/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 §

424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to §§ 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (15), (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/supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider's 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.

*MACs shall save a*ll documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) in PDF format. The date on the CAP and reconsideration request decisions *shall* 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 *written* 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 the *provider/supplier* 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*'s* 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*'s* or supplier's application;
- All background information and investigative data the hearing officer used to make their decision*, i*ncluding any on-site visit reports*, and* the MAC's recommendation for administrative action based on the on-site visit; *and*
- 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/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/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/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/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/supplier *must* submit a reconsideration 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 the date of filing. See section *10.6.18(D) if this chapter* 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
Center for Program Integrity
Provider Enrollment & Oversight Group
Attn: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop AR-19-51
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. *Pursuant to 42 C.F.R. § 498.22(d), CMS may extend t*he time limit *to submit a reconsideration request* if "good cause" 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.

CMS will make *the* 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 before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. *The email shall include an explanation of why the MAC believes good cause exists.* 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. Therefore, 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, 2024*. The provider is presumed to have received the initial determination on *April 6, 2024*. The provider submits a reconsideration request by mail that is received on *June 5, 2024 -- 60 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*'s* or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider*'s* or supplier's enrollment information, including its correspondence *mailing* 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 *physician or practitioner*, *an* authorized/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/she/they* has the authority to represent the provider/supplier. This statement is sufficient to constitute notice *of appointment*.
- If the representative is not an attorney, the provider/supplier must file written notice of the appointment of a representative with *CMS or the MAC*. This notice of appointment must be signed by the individual *physician or practitioner*, or *an* authorized/delegated official. The signature need not be original and can be electronic.
- Authorized/delegated officials for groups cannot sign and submit a CAP and/or reconsideration request on behalf of a reassigned *individual physician or practitioner* without the *individual practitioner* submitting a signed statement authorizing that *official* from the group to act on *his/her/their* behalf.

(**NOTE:** The *C*ontact *P*erson (as listed in *S*ection 13 of the Form CMS- 855*I, CMS-855A, CMS-855B, CMS-855S, or CMS-20134, or Section 6 of the Form CMS-855O*) does not

qualify as a "*properly appointed* representative" for purposes of signing a *CAP and/or* reconsideration request *without a signed notice of appointment from the individual physician or practitioner, or an authorized/delegated official. See section 10.6.18(A)(7) of this chapter for additional information regarding representatives for CAPs and reconsideration requests.*)

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 *in section 10.7 of this chapter*) 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 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, the MAC shall dismiss the CAP and/or reconsideration request using the applicable model dismissal letter *from section 10.7 of this chapter.*

7. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider/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/she/they have* the authority to represent the provider/supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, *the individual physician or practitioner,* or authorized/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/supplier.

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

*Pursuant to 42 C.F.R. § 424.530(b), i*f a provider*'s* or supplier's enrollment application is denied, the provider/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 provide 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 *a* CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider/supplier that currently has a pending CAP and/or reconsideration request or is still within the submission time period *following a denial* unless instructed by CMS to do so. *If the MAC confirms that the provider/supplier submitted an enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application, the MAC shall return the application, consistent with section 10.4.1.4.2(A) of this chapter*.

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

To be accepted a CAP submission:

a) Must contain, at a minimum, verifiable evidence that the provider/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)(5) of this chapter* 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 *physician or practitioner, an* authorized/delegated official, or a properly appointed representative;
d) Should include all documentation and information the provider/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 *including* § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but with respect to the other grounds. *The other denial bases may only be reviewed as a reconsideration.*
    ii) If the provider/supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter using the model acknowledgement letter *(see section 10.7 of this chapter)*.
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.
    ii) 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. *The other revocation bases may only be reviewed as a reconsideration.*
    iii) If the provider/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/supplier using the model acknowledgment letter.

3. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider/supplier, the MAC shall use the model acknowledgment letter *in section 10.7 of this chapter* 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 *mailing* 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/supplier/representative* an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter *in section 10.7 of this chapter*.

4. Dismissing a CAP

A CAP shall be dismissed when the provider/supplier does not have the right to submit a CAP for the initial determination, or when the provider/supplier submitted the CAP improperly or untimely (see Section 10.6.18(B)(2) *of this chapter*). 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/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 *in section 10.7 of this chapter* and review the reconsideration request in accordance with the instruction in Section 10.6.18(C) *of this chapter*.

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/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 § 424.530(a)(1) or revocation under § 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. *Pursuant to § 405.809(b), 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/supplier came into compliance. Consider the following example:

> Example 1: *Dr. Smith's enrollment* is revoked under 42 C.F.R. § 424.535(a)(1) because *his* required license has been suspended. *Dr. Smith* timely submits a CAP *with* evidence that *his* licensure has been reinstated*, effective June 1, 2024,* and is currently active. After confirming the status of current licensure, the MAC *renders* a favorable CAP decision because the *Dr. Smith* has corrected the licensure issue that led to enrollment denial or revocation. *Dr. Smith's enrollment is reinstated, effective June 1, 2024.*

If the provider/supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include *a statement* in the decision letter that the CAP was reviewed only in regard to *the denial under* 42 C.F.R. § 424.535(a)(1).

If the provider/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/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 *provider/*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/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/supplier/representative*, 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 CAP/envelope or the *correspondence* mailing address on the provider's *or* supplier's enrollment record if no return address is included on the CAP. 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/supplier/representative* by issuing a favorable decision letter following the applicable model CAP letter *in section 10.7 of this chapter*. 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

Dr. Happy's initial enrollment application is denied on March 1, 2024. *Dr. Happy* submits a CAP showing that, as of *March 20, 2024, they were* in compliance with all Medicare requirements. If the MAC approves the CAP, the effective date for *Dr. Happy's* Medicare *enrollment and* billing privileges should be *March 20, 2024*, as that is the day on which *Dr. Happy* came into compliance with all Medicare requirements. The 30-day retrospective billing *period under 42 C.F.R. § 424.521* should not be applied in this situation because *§ 424.521(a)(1) requires that the provider/supplier has met all program requirements during the 30-day period*. *That is* not the case here. *Dr. Happy* was not in compliance with all Medicare requirements until March 20.

b. Revocations

Dr. Smile's medical license is suspended on *June 3, 2024. Dr. Smile's* Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June *15, 2024. Dr. Smile* then submits a CAP showing *that her license was reinstated* as of July *1, 2024. Pursuant to § 405.809(b)(1)(i), if* the MAC approves the CAP, the effective date for reactivation of the *Dr. Smile's* Medicare *enrollment* billing privileges *will be July 1, 2024,* as that is the *date* on which *Dr. Smile* came into compliance with all Medicare requirements. The 30-day retrospective billing *period under § 424.521* does not 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/representative* who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. *If submitted via mail, the request to* withdraw 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 *before the CAP determination is issued*, it shall send a letter or e-mail to the *provider/supplier/representative* acknowledging receipt of the request to withdraw the CAP and advising that the *CAP* has been dismissed, utilizing the applicable model letter *in section 10.7 of this chapter*.

8. Concurrent Submission of CAP and Reconsideration Request

If a provider/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 a revocation of billing privileges under § 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 § 424.530(a)(1) or § 424.535(a)(1). If the MAC renders a favorable decision as it relates to § 424.530(a)(1) or § 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(C)(8) *of this chapter* 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 *CAP* 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/supplier/representative* 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, *the MAC shall* not include further appeal rights for a CAP only decision.

- The MAC shall notify the *provider/supplier/representative* of the denial of the CAP via the applicable CAP model letter *in section 10.7 of this chapter*.

- The provider/supplier may continue with the appeals process *only* if it has filed a reconsideration request or is preparing to *timely* submit such a request.

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

C. Reconsideration Requests

1. Background

A reconsideration request allows the provider/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/supplier the opportunity to correct the deficiencies that led to the initial determination.

2. Requirements for Reconsideration Request Submission

To be accepted, a reconsideration request:

a. Must, at a minimum, state the issues *and/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 10.6.18(A)(4)-(5) of this chapter* 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*;*

d. *Must be* signed by the individual physician/practitioner, *an* authorized or delegated official, or a properly appointed representative; *and*

e. Should include all documentation and information the provider/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 *in section 10.7 of this chapter* 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 *mailing* address on the provider's or supplier's enrollment record. In the acknowledgment letter/email, 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/email* in the reconsideration file. If the reconsideration *request* should have been submitted to CMS, the MAC shall not send the *provider/supplier/representative* an acknowledgment *letter/email*. 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) *of this chapter*).

If the 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/supplier/representative* an acknowledgment *letter/email*. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter *section 10.7 of this chapter*.

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)-*(5) of this chapter* for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the *provider/supplier/representative*, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time *before* reconsideration decision *is* 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*, including*:

- 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/supplier subsequent to the initial determination.

If the appealing party *(i.e. the provider/supplier)* 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/supplier/representative* 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 *correspondence* mailing address on the provider's *or* supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also fax the *reconsideration* decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter in *section 10.7 of this chapter* and include:

- The regulatory basis to support each reason for the initial determination;
- A summary of the documentation that the *provider/supplier/representative* 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 *or CMS* 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/supplier/representative* 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- regulatory guidance* supporting the decision, as well as any documentation reviewed;

- *A*n explanation of how the provider/supplier does not meet the Medicare enrollment criteria or requirements *(if applicable)*;

- 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/supplier/representative* must include with its appeal:

    - *name/legal business name;*
    - *provider transaction access number (PTAN) (if applicable);*
    - *tax identification number/employer identification number (TIN/EIN);*
    - *NPI; and*
    - *a copy of the reconsideration decision.*

Consider the following example for a Site Visit Revocation:

> If a provider/supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall *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.). To do so the MAC* shall review the *(1)* initial determination, the enrollment application preceding the site visit, the site investigation report(s), *(2)* the reconsideration request and supporting documentation, *and (3)* any other relevant information. If the MAC finds that an error was made during the site visit, 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/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 § 424.535(a)(5) using the applicable model letter *in section 10.7 of this chapter*.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's *enrollment and* billing privileges to an approved status as of the effective date determined in the reconsidered determination *and/*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/supplier/representative* at the return

address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider/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/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 applicable contractor.

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/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/supplier/representative* via the applicable model letter to again request the additional information/documentation within 10 calendar days of *the missed deadline*. 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. *The email to PEOG shall include copies of the reconsideration decision and second request for additional information/documentation.*

6. Withdrawal of Reconsideration Request

The *provider/supplier/representative* who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. *If submitted via mail, the request to withdraw the* 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 *before the reconsidered determination is issued*, it shall send a letter or e-mail to the *provider/supplier/representative* acknowledging receipt of the *withdrawal* request and advising that the *reconsideration* request has been dismissed, utilizing the applicable model letter *in section 10.7 of this chapter*.

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

Under 42 C.F.R. § 424.530(c) *and §* 424.535(e), a *provider/supplier/representative* 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, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program. The *denial or* revocation may be reversed, at the discretion of CMS, if the *provider/supplier* terminates and submits proof that it has terminated its business relationship with the individual or organization against whom the adverse action is imposed within 15 days of the

revocation determination. (For reversal of denials, the timeframe within 30 days of the denial notification.) 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/supplier/representative* to reverse a denial or revocation due to the termination of the business relationship, 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*. For example,* CMS *may* contact the MAC to rescind the revocation or reinstate the provider*'s* 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 *in section 10.7 of this chapter*. 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/supplier/representative* 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.

10. Reconsideration Requests Related to Opt-Outs

a. General Instructions

The MACs shall process all reconsideration requests for initial determinations pertaining to opt-outs, as described at 42 C.F.R. § 498.3(b)(19). Assuming all other requirements are met (e.g. timeliness, signature, etc.) MACs shall accept reconsideration requests related to all of the following:

- *automatic renewal of opt-out status;*
- *untimely cancellation of opt-out auto-renewal;*
- *early cancellation of opt-out status;*
- *termination of opt-out status; and*
- *effective date of opt-out status.*

When reviewing opt-out reconsideration request, particularly those that involve automatic renewal of the opt-out period, the MAC shall confirm that all notices were sent to the current

address on file for the physician/practitioner within the timeframes required by CMS direction.

Reconsideration requests regarding opt-outs are subject to the same requirements discussed elsewhere in this chapter pertaining to proper signature. The MACs shall follow applicable instructions elsewhere in this chapter regarding receipt acknowledgement, development, and dismissal of opt-out reconsideration requests. The MACs shall use the appropriate Model Letters in Section 10.7 of this Chapter to issue letters regarding opt-outs reconsideration requests. The MACs shall include Further Appeal Rights in all reconsideration request decisions pertaining to opt-outs.

If the MAC encounters an opt-out appeal that is not addressed by these instructions or requires clarification, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action, including acknowledging receipt of the reconsideration request.

b. Examples

Below are common examples of reconsideration requests that may be submitted.

Example 1 – Untimely Cancellation of Auto-Renewal.

Dr. Red is a licensed psychiatrist who initially opted-out of Medicare effective January 1, 2020. His opt-out status automatically renewed on January 1, 2022, and January 1, 2024. On February 10, 2024, the MAC receives a reconsideration request from Dr. Red stating that he wishes to cancel his opt-out and enroll in the Medicare program as a supplier. The MAC accepts this reconsideration request as both a termination request and a cancellation request. The MAC confirms that the auto-renewal notices were sent to Dr. Red at his address of record at least 90 days before his opt-out status renewed. Because Dr. Red's request was received more than 90 days after his initial effective date, the MAC determines that he has failed to properly and timely terminate his opt-out status. In addition, because it is more than 90 days before his opt-out status will automatically renew (i.e. 90 days before January 1, 2026), the MAC also determines that Dr. Red has failed to properly and timely cancel the automatic renewal of his opt-out.

Example 2 – Untimely Termination Request

Dr. Orange is a licensed neurologist who has never previously enrolled in Medicare nor opted-out of Medicare. They submitted an opt-out affidavit to the MAC which was signed on June 1, 2024. In a letter dated July 1, 2024, the MAC approves Dr. Orange's affidavit, effective June 1, 2024. The initial approval letters states that Dr. Orange has until August 30, 2024 to terminate their opt-out. On September 2, 2024, the MAC receives Dr. Orange's termination request. On September 3, 2024, the MAC returns the termination request as untimely. Dr. Orange responds on September 4, 2024 requesting reconsideration. The MAC accepts the reconsideration request and confirms that the approval letter was sent to Dr. Orange's address of record. Because Dr. Orange's termination request was received more than 90 days after the effective date of their opt-out status, the MAC determines that they failed to properly terminate their opt-out status. In addition, because it is more than 90 days before their opt-out status will automatically renew (i.e. 90 days before June 1, 2026), the MAC also determines that Dr. Orange has failed to properly and timely cancel the automatic renewal of their opt-out status.

Example 3 – Opt-out Effective Date Appeal

Dr. Yellow was enrolled in Medicare as an individual physician. With her initial CMS-855I

enrollment application, Dr. Yellow included a form CMS-460, and was enrolled as a participating physician. She submitted an opt-out affidavit to the MAC which was signed on August 12, 2024. In a letter dated September 2, 2024, the MAC approved Dr. Yellow's affidavit, effective August 12, 2024. On September 9, 2024, the MAC receives Dr. Yellow's reconsideration request to challenge the effective date of her opt-out approval. Dr. Yellow argues that her opt-out approval status should be October 1, 2024 because she was previously enrolled as a participating physician. The MAC finds that Dr. Yellow submitted the opt-out affidavit more than 30 days before the start of the next calendar quarter (October 1, 2024). Therefore, the MAC issues a favorable reconsideration decision and changes Dr. Yellow's opt-out status effective date to October 1, 2024.

D. Further Appeal Rights for Reconsidered Determinations

1. Administrative Law Judge (ALJ) Hearing

CMS or a provider/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 *CRD of the DAB* within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the *DAB* 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/they* 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. *See section 10.6.18(A)(3) of this chapter for additional information.*

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.

F. External Monthly Reporting Requirements for CAPs and Reconsideration Requests

Using the provider enrollment appeals reporting template, the *Contractor* shall complete all columns listed for all appeals *(i.e. CAPs and reconsideration requests)* except those submissions that are referred to CMS for processing. No column shall be left blank (except Column N). 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 reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g. 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's appeal submissions, as well as outcomes for all appeals previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January appeals). ***IMPORTANT:*** *All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.*

The response in Column A labeled, "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)-(18).

- **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)-(23).

- **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.

- ***Opt-Out***
  Reconsideration request pertaining to an individual physician/practitioner opt-out status. If "Opt-Out" is listed, enter "405.450" in Column G.

- **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 B labeled, "Provider/Supplier Name" shall be the legal business name (LBN) of the provider/supplier exactly as it is spelled and formatted in the PECOS

enrollment record (including capitalization, abbreviations, and punctuation). This column shall not be blank.

The response in Column C labeled, "NPI" shall be the provider's or supplier's NPI number. If a provider/supplier has multiple NPIs, each shall be separated with a semicolon followed by a space (e.g. "1234567890; 1123456789"). This column shall not be blank.

The response in Column D labeled, "EID" shall be the provider's or supplier's PECOS enrollment identification number (EID) as it appears in PECOS. On the rare occasion that no EID is available, the contractor shall enter "N/A". This column shall not be blank.

The response in Column E labeled, "PTAN(s)" shall be the provider's or supplier's Provider Transaction Access Number(s) (PTAN(s)), or other Medicare ID number. If the provider/supplier has not yet been assigned a PTAN or Medicare ID, the contractor shall enter "N/A". If a provider/supplier has multiple PTANs or Medicare IDs, each shall be separated with a semicolon (e.g. "12AB345; ZZ2356"). This column shall not be blank.

The response in Column F labeled, "Contractor" shall be one of the following, as appropriate. This column shall not be blank. No other formats are acceptable.

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

The response in Column G labeled, "Regulatory Authority," shall be in the following formats. If none of these applies, the contractor shall enter "N/A" and provide an explanation in the Comments Column N. No other formats are acceptable. This column shall not be blank.

- ***424.520***
  This exact format shall be used for all effective date appeals

- ***405.450***
  This exact format shall be used for all opt-out appeals

- ***424.530(a)([#])([#])***
  This format shall be used for denial appeals. The contractor shall enter the applicable section numbers [#], as appropriate. For example: 424.530(a)(1) or 424.530(a)(1)(9)

- ***424.535(a)([#])([#])***
  This format shall be used for revocation appeals. The contractor shall enter the applicable section numbers [#], as appropriate. For example: 424.535(a)(5) or

424.535(a)(1)

The response in Column H labeled "Provider/Supplier Standards" shall be the regulatory citations for any provider/supplier standard(s) cited in the initial determination. For example, a denial for an IDTF may cite § 410.33(g)(4); the contractor would enter "410.33(g)(4)" in this column. If no provider/supplier standards were cited in the initial determination, the contractor shall enter "N/A". This column shall not be blank.

The response in Column I labeled "CAP or Reconsideration" shall be one of the following. No other formats are acceptable. This column shall not be blank.

- ***CAP***
- ***Reconsideration***

The response in Column J labeled, "Date Received," shall be the date the contractor received the appeal from the provider/supplier or representative (in mm/dd/yyyy format); no other formats are acceptable. This column shall not be blank.

The response in Column K labelled, "Date Receipt Acknowledgement Sent," shall be one of the following:

- ***[mm]/[dd]/[yyyy]***
  The date the receipt acknowledgement email/letter was sent to the provider/supplier or the representative, in "mm/dd/yyyy" format. No other date formats are acceptable.

- ***Not Yet Sent***
  If a receipt acknowledgement email/letter has not been sent at the time the monthly report is sent to CMS.

- ***N/A***
  If a receipt acknowledgement email/letter is not required for that case.

The response in Column L labelled, "Final Decision Result," shall be one of the following. If the appeal submission is referred to CMS for processing then the appeal *shall* not be included on the MAC Monthly Appeals Report.

- **Not Actionable**
  Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (*e.g.*: Fingerprints have received a passed designation, initial determination has been reopened and revised*, or CMS has instructed the Contractor to rescind the initial determination*).

- **Favorable**
  Contractor 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.

- **Unfavorable**
  Contractor upholds the initial determination.

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

- ***In Process***
  The final decision has not been issued.

- **Withdrawn**
  *The p*rovider/supplier *or representative* has submitted written notice of its intent to withdraw its appeal *before the Contractor issued a final determination*.

The response in Column M labelled, "Date Final Decision Issued," shall *be either the date the final determination was issued (in mm/dd/yyyy format) or* "In Process" *(*if a final decision has not been issued at the time the monthly report is sent to CMS*). No other formats are acceptable. This column shall not be blank.*

The response in Column N labelled, "Comments" shall be any comments the contractor has regarding the appeal case, including details about why a case is labelled as "Other" in Column A. This column may be blank.

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.

10.7.11 – Reconsideration Request Model Letters

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

Instruction

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

A. Reconsideration Request Withdrawn Acknowledgement Template

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re: [Provider/Supplier Name]

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

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request *Withdrawal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

B. Reconsideration Request Receipt Acknowledgement Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

1. Email Template

To: [Email address provided by the person who submitted the reconsideration request]

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

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

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

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 to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Hard-Copy Letter Template

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

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 to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. § 498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

C. Reconsideration Request Decision Email Template to Provider/Supplier/Representative

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration Request]

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

(Be sure to attach a copy of the final decision[s] in PDF format.)

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

Please see the attached decision regarding your Medicare Provider Enrollment Reconsideration Request.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

D. Reconsideration Request Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via

fax if a valid fax number is available. *Be sure to attach a copy of the letter or correspondence that rendered the reconsideration request moot.)*

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [*initial determination (e.g. denial of your Medicare enrollment application, approval of your Medicare enrollment application, or revocation of your Medicare billing privileges)*] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of the denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the reconsideration request is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

E. Untimely Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request *Dismissal*

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name], based on the initial determination letter dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your reconsideration request as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A reconsideration request must be received within 65 calendar days of the date of the initial determination letter. Your reconsideration request was not received by [MAC Name] until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You have failed to show good cause for your late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

F. Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination letter.

(If the submission was missing the facts or issues, use the following.) [Your submission did not clearly identify the facts or issues with which you disagree and your reasons for disagreement. The requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 10 of the Medicare Program Integrity Manual.]

(If the submission was not properly signed, use the following.) [[MAC Name] is unable to accept your reconsideration request as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 10 of the Medicare Program Integrity Manual.*]*

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. Not Eligible to Submit Reconsideration Request Dismissal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the [reconsideration request] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [reconsideration request] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights related to provider enrollment extend only from initial determinations.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Reconsideration Request Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request *Development Request*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your reconsideration submission, received on [Month] [DD], [YYYY]. *(If the submission is missing the facts or issues, use the following.) [Your submission does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [MAC Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper reconsideration that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised reconsideration submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]*

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.6.18. [MAC Name] is requesting that you submit a reconsideration request that is properly signed by the individual provider, supplier, the authorized or delegated official, or a representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your

reconsideration submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been

granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-17)
- 42 C.F.R. § 424.530(a)(denial reason 1-17)

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-17).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], a disciplinary hearing was held regarding the medical license of Jane Doe. However, on [Month] [DD], [YYYY], the Wisconsin Medical Board declined to take disciplinary action against Jane Doe's medical license. As a result, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] related to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], requesting additional informed needed to process the

revalidation application to completion for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, if provided, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex.: On [Month] [DD], [YYYY], John Smith's revalidation application was approved with a gap in his billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. However, as indicated above, [MAC Name] has determined that the reactivation effective should be [Month] [DD], [YYYY]. As a result of the change in the reactivation effective date, the gap in John Smith's Medicare billing privileges has been eliminated.)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the reactivation effective date for [Provider/Supplier Name].

You must resubmit any claims that were denied or not previously submitted due to the former gap in your Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or

CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

K. Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] in response to a determination of the effective date of participation in the Medicare program. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)
- *(Other effective date regulations may be included)*

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the determination of the effective date.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial enrollment application, which was subsequently rejected for failure to timely respond to a development request for additional information/documentation. As part of his reconsideration request, John Smith submitted an email receipt showing that he timely responded to the development request. As a result, [MAC Name] will modify John Smith's Medicare effective date to [Month] [DD], [YYYY].)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will modify/has modified] the enrollment effective date to [Month] [DD], [YYYY].

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]
Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

L. Favorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-2*3*)
- 42 C.F.R. § 424.535(a)(revocation reason 1-2*3*)

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all

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

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has reviewed and/or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY].

Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1- 23).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the provider or supplier arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. However, on [Month] [DD] [YYYY], the Wisconsin medical board issued an order reversing the license suspension back to its implementation date based on the outcome of a hearing. As a result, [MAC Name] is overturning the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).)

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on Chapter 10 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation

must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

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1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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.

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- 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

M. Unfavorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-17)
- 42 C.F.R. § 424.530(a)(denial reason 1-17)

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the reconsideration request.]

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-17).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. Jane Doe did not submit any documentation to demonstrate that her medical license was not suspended. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

N. Unfavorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the reconsideration request received by [MAC Name] in response to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. § 424.540*(d)(2)* (Other applicable regulations or MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith's Medicare enrollment was deactivated for failing to timely respond to a revalidation request. On [Month] [DD], [YYYY], John Smith submitted a revalidation application, which was processed and approved. Per the MPIM, Ch. 10, Section 10.4(K), John Smith's Medicare enrollment was reactivated, but with a gap in his Medicare billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. John Smith's reconsideration request did not demonstrate an error in the determination of his reactivation effective date.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was

made in the determination of a reactivation effective date resulting in a gap in your Medicare billing privileges. As a result, your reactivation effective date will remain [Month] [DD] [YYYY].

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)

- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

O. Unfavorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an effective date of enrollment determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)
- *(Other effective date regulations may be included)*

OTHER APPLICABLE AUTHORIT*(Y/IES)*:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the

reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial Medicare enrollment application. On [Month] [DD], [YYYY], [MAC Name] sent a development request to John Smith for additional documentation/information to continue processing his enrollment application.

However, John Smith did not submit the requested documentation within 30 days. As a result, [MAC Name] properly rejected John Smith's Medicare enrollment application received on [Month] [DD] [YYYY]. On [Month] [DD] [YYYY], John Smith submitted another Medicare enrollment application, which was processed and subsequently approved with an effective date of [Month] [DD], [YYYY] in accordance with 42 C.F.R. § 424.520.)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that no error was made in the determination of your effective date of participation in the Medicare program. As a result, the effective date of participation will remain the same.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
  - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
  - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies

Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

P. Unfavorable Reconsideration Request Model Letter for Revocation Determination

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-2*3*)
- 42 C.F.R. § 424.535(a)(revocation reason 1-2*3*)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. § *424.535(c) (delete if no re-enrollment bar established)*
- (Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, "[MAC Name] has denied or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1-2*3*).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that the suspension of her medical license was rescinded. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare enrollment application under 42 C.F.R. § 424.535(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the implementation of a revocation. As a result, the revocation of your Medicare billing privileges is upheld.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
    - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
    - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

- 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.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

Q. Reconsideration Further Information Required for Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via

fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration.]
Subject: Medicare Provider Enrollment Reconsideration re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration] (If submitted on behalf of an organization or group) [Address] (Address from which the Reconsideration was sent)
[City], [State] [Zip Code]

Re: Reconsideration Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

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

On [Month] [DD]. [YYYY], [MAC Name] issued a reconsideration decision. As stated in the [Month] [DD], [YYYY] reconsideration decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC Reconsideration Receipt Address] [MAC Reconsideration Receipt Email Address] [MAC Reconsideration Receipt Fax Number]
If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Signature of Hearing Officer] (May be electronic) [Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

R. Unfavorable Reconsideration Request Decision Model Letter for Opt-Out Termination/Cancellation

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- *42 C.F.R. § 498.3(b)(19)*
- *42 C.F.R. § 405.450*
- *42 C.F.R. § 405.405*
- *42 C.F.R. § 405.455*
- *42 C.F.R. § 405.[xxx] (as applicable)*

OTHER APPLICABLE AUTHORITIES:

- *Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39*
- *Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12*
- *(Ex: 42 C.F.R. §)*
- *(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider/supplier, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the provider/supplier, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments

made by the provider/supplier in its reconsideration request. The MAC shall then conduct analysis of the provider/supplier arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the [insert reason for opt-out appeal (e.g. automatic renewal of your opt-out status/return of your cancellation request/return of your termination request/approval of your opt-out affidavit)]. As a result, [describe outcome of opt-out status (e.g. you will remain opted-out until at least January 1, 2025)]. Please see below for additional appeal rights.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. *Clicking Register on the DAB E-File home page;*
2. *Entering the information requested on the "Register New Account" form; and*
3. *Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*

    - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
    - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *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.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

S. Favorable Reconsideration Request Decision Model Letter for Opt-Out Termination/Cancellation

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- *42 C.F.R. § 498.3(b)(19)*
- *42 C.F.R. § 405.450*
- *42 C.F.R. § 405.405*
- *42 C.F.R. § 405.455*
- *42 C.F.R. § 405.[xxx] (as applicable)*

OTHER APPLICABLE AUTHORITIES:

- *Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39*
- *Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12*
- *(Ex: 42 C.F.R. §)*
- *(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider/supplier, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the provider/supplier, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the provider/supplier in its reconsideration request. The MAC shall then conduct analysis of the provider/supplier arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

[MAC name] finds that [describe error/facts that led to favorable decision]. As a result, [describe outcome of opt-out status (e.g. the automatic renewal of your opt-out status has been cancelled or your opt-out status has been terminated)].

*This decision is a **FAVORABLE DECISION**. Please see below for additional appeal rights.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

4. *Clicking Register on the DAB E-File home page;*

5. *Entering the information requested on the "Register New Account" form; and*
6. *Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*
  - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
  - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

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- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
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If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

T. Unfavorable Reconsideration Request Decision Model Letter for Opt-Out Effective Date

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely

submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- *42 C.F.R. § 498.3(b)(19)*
- *42 C.F.R. § 405.405*
- *42 C.F.R. § 405.410*
- *42 C.F.R. § 405.425*
- *42 C.F.R. § 405.445*
- *42 C.F.R. § 405.455*
- *42 C.F.R. § 405.450*
- *42 C.F.R. § 405.[xxx] (as applicable)*

OTHER APPLICABLE AUTHORITIES:

- *Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39*
- *Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12*
- *(Ex: 42 C.F.R. §)*
- *(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider/supplier, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the provider/supplier, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the provider/supplier in its reconsideration request. The MAC shall then conduct analysis of the provider/supplier arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

*This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that there was no error made in the opt-out effective date determination. As a result, the effective date of your opt-out status remains unchanged. Please see below for additional appeal rights.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/.

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7. *Clicking Register on the DAB E-File home page;*
8. *Entering the information requested on the "Register New Account" form; and*
9. *Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.*

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All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*
  - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
  - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

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If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

U. Favorable Reconsideration Request Decision Model Letter for Opt-Out Effective Date

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [Day], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent)
[City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on [Provider/Supplier Name]'s opt-out status. The initial opt-out approval was issued in a letter dated [Month] [DD], [YYYY], effective [Month] [DD], [YYYY]. (If the opt-out status has auto-renewed, include the following [Subsequently, on [Month] [DD], [YYYY], the opt-out period was automatically renewed for another two years.] The reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (If the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

OPT-OUT AUTHORITIES:

- *42 C.F.R. § 498.3(b)(19)*
- *42 C.F.R. § 405.405*
- *42 C.F.R. § 405.410*
- *42 C.F.R. § 405.425*
- *42 C.F.R. § 405.445*
- *42 C.F.R. § 405.455*
- *42 C.F.R. § 405.450*
- *42 C.F.R. § 405.[xxx] (as applicable)*

OTHER APPLICABLE AUTHORITIES:

- *Medicare Benefit Policy Manual (MBPM) Ch. 15 §§ 40.1 – 40.39*
- *Medicare Program Integrity Manual (MPIM) Ch. 10 § 10.6.12*
- *(Ex: 42 C.F.R. §)*
- *(Ex: Medicare Program Integrity Manual chapter 10, section 10.XX)*

EXHIBITS:

- *Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD], [YYYY].)*
- *Exhibit 2: (Ex: Opt-out approval letter, dated [Month] [DD], [YYYY].)*

(In this section list each document submitted by the provider/supplier, as well as the original opt-out affidavit and opt-out approval letter. If auto-renewal letter(s) were sent to the provider/supplier, those shall be included as exhibits. Each exhibit should include the date, as well as a brief description of the document. The MAC shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, auto-renewal letters etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section shall summarize the statements/arguments made by the provider/supplier in its reconsideration request. The MAC shall then conduct analysis of the provider/supplier arguments based on the applicable regulations and sub-regulations (MPIM). It is insufficient to state a reconsideration decision without explaining how and why the decision was reached.)

DECISION:

(A short conclusory restatement.)

*This decision is a **FAVORABLE DECISION**. [MAC name] concludes that the correct effective date of our opt-out status is [Month] [DD], [YYYY]. Please see below for additional appeal rights.*

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your 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, you first need to register a new account by:

1. *Clicking Register on the DAB E-File home page;*
2. *Entering the information requested on the "Register New Account" form; and*
3. *Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your 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, you may file your 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.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- *A signed request for hearing that:*
  - *Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and*
  - *Specifies the basis for contending that the findings and conclusions are incorrect;*
- *The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.*

In addition, the following identifying information is required with all ALJ hearing requests:

- *Your legal business name*
- *Your Medicare PTAN (if applicable)*
- *Tax Identification Number (TIN) or Employer Identification Number (EIN)*
- *A copy of the Hearing Officer or the CMS Regional Office (RO) decision*

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- *Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.*
- *A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.*
- *Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.*
- *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.*

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies

Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

10.7.12 – Deactivation Model Letters

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

(To be sent by hard-copy mail, and via email if email address is listed in the provider/supplier correspondence mailing address on the enrollment record. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

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

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-8]

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

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

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicare billing data and found that you have not submitted any Medicare claims in more than [six or twelve] consecutive calendar months prior to the date of this letter.)

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

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

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal 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/their behalf.]

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

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

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

The rebuttal should be sent to the following:
[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM ET/CT/MT/PT] and [x:00 AM/PM ET/CT/MT/PT].

Sincerely,

[Name] [Title] [Company]

10.7.13 – Deactivation Rebuttal Model Letters

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

Instruction

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

A. *Deactivation* Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Development Request*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY], *in response to the deactivation of [Provider/Supplier Name]'s billing privileges*.

(If the submission is not properly signed, use the following.) *[*Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 10, Section 10.*4.8.1(C)(1)*. [Contractor Name] requests that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal 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/their behalf.] Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.*]*

(If the submission is missing a statement by the attorney, use the following.) *[*Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [Contractor Name] requests that you submit a rebuttal that includes an attorney statement that he/she/they have the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.*]*

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/their/its behalf, use the following.) *[*Your submission is missing a written notice of the appointment of a representative signed by the provider or

supplier. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal 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/their behalf. [Contractor Name] requests that you submit written notice of the appointment of a representative that is properly signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.*]*

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

B. *Deactivation* Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Development Request*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Optional)

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

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

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]

Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

C. *Deactivation* Rebuttal Moot Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

D. *Deactivation* Rebuttal Facts or Issues and Reasons for Disagreement Development Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address

on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Development Request*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your rebuttal submission on behalf of [Provider/Supplier Name], received on [Month] [DD], [YYYY].

As stated in the deactivation letter dated [Month] [DD], [YYYY], to be accepted and reviewed, your rebuttal must state the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement. The rebuttal received on [Month] [DD], [YYYY] does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [Contractor Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper rebuttal that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised rebuttal submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. *Deactivation* Rebuttal Withdrawn Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address

on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Withdrawal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

F. *Deactivation* Rebuttal Receipt Acknowledgement Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. [Contractor Name] will further review the information and documentation submitted in the rebuttal and will render a final determination regarding the deactivation of *[Provider/Supplier Name]'s* Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

G. Final *Deactivation* Rebuttal Decision Email Template

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

To: [Email address provided by the person who submitted the rebuttal and email address listed in the provider/supplier correspondence mailing address on the enrollment application if different from the email address on the rebuttal submission.]

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

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

Please see the attached determination regarding your rebuttal, submitted on behalf of [Provider/Supplier Name].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

H. *Deactivation* Rebuttal Dismissal Model Letters

1. Untimely *Deactivation* Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter deactivating [Provider/Supplier Name]'s Medicare billing privileges dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 15 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for the late request. Therefore, [Contractor Name] is unable to render a determination in this matter and [Provider/Supplier]'s Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Improper Signature *Deactivation* Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter deactivating [Provider/Supplier Name]'s Medicare billing privileges dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual *practitioner*, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned *practitioner* without the *practitioner* submitting a signed statement authorizing that individual to act on their behalf. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you provide a properly signed submission and permitted an additional 15-calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. No Rebuttal Rights *Deactivation* Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Submission *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], submitted on behalf of [Provider/Supplier Name].

[Contractor Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges *or enrollment* does not afford the opportunity for a rebuttal. *Only a provider/supplier whose enrollment is stayed under 42 C.F.R. § 424.541, or whose billing privileges are deactivated under § 424.540 may file a rebuttal.* As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. More than One Submission *Deactivation* Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal submitted on behalf of [Provider/Supplier Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[Contractor Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [Contractor Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY] *(list all dates)*. As a result, [Contractor Name] is dismissing your rebuttal *received on [Month] [DD], [YYYY] (list all dates)* and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. No Specification of Why the Provider/Supplier Disagrees with Enrollment Deactivation and Reasons for Disagreement Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal *Dismissal*
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal submitted on behalf of [Provider/Supplier Name] based on the deactivation letter, dated [Month] [DD], [YYYY].

[Contractor Name] is unable to accept your rebuttal as it does not specify the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement. The requirement to identify the facts or issues with which you disagree and your reasons for disagreement was stated in the deactivation letter, dated [Month] [DD], [YYYY], as well as in 42 C.F.R. § 424.546(b), and in Chapter 10 of the Medicare Program Integrity Manual. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you identify the facts or issues identified in the deactivation letter with which you disagree and your reasons for disagreement and permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.])

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

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

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

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

On [Month] [DD], [YYYY], [Contractor Name] reopened the deactivation for [Provider/Supplier Name] and issued a *[letter reversing the deactivation or a revised deactivation letter]*. This *[letter reversing the deactivation or revised deactivation letter]* rendered the issue set forth in your rebuttal no longer actionable. For your convenience a copy of the *[letter reversing the deactivation or revised deactivation letter]* is attached. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

(The contractor shall include PDF copy of the letter that rendered the rebuttal moot (e.g. the *letter reversing the deactivation or revised deactivation letter*).)

J. Favorable *Deactivation* Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. (If the rebuttal was timely, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)([1-8])

OTHER APPLICABLE AUTHORIT[Y/IES]: (list any authorities cited in analysis)

- 42 C.F.R. § 424.546
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable).
- (Ex.: If deactivation based non-compliance, list supplier standards)
- (Ex.: If deactivation based on failure to report, list regulation that requires reporting)
- *(Ex.: If deactivation under § 424.540(a)(8), list § 424.550(b)(1))*

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);

- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, as well as a brief description of the document. The contractor shall also include other documentation not submitted by the provider or supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. *The deactivation letter shall be included as an Exhibit.*)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section shall summarize the statements made by the provider or supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in "Other Applicable Authorities." It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

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

This is a **FAVORABLE DETERMINATION**. To effectuate this determination, [Contractor name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the Contractor shall state what information is needed from the provider or supplier in this rebuttal determination. Contractors shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m. ET/MT/CT/PT] and [x:00 a.m./p.m. ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]

[Position of Hearing Officer]
[Contractor Name]

K. Unfavorable *Deactivation* Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: *Deactivation* Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. (If the rebuttal was timely, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The deactivation letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)([1-8])

OTHER APPLICABLE AUTHORIT[Y/IES]: (list any authorities cited in analysis)

- 42 C.F.R. § 424.546
- Medicare Program Integrity Manual chapter 10.XX (If applicable)
- (Ex.: If deactivation based non-compliance, list supplier standards)
- (Ex.: If deactivation based on failure to report, list regulation that requires reporting)
- *(Ex.: If deactivation under § 424.540(a)(8), list § 424.550(b)(1))*

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);

- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, as well as a brief description of the document. The Contractor shall also include other documentation not submitted by the provider or supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. *The deactivation letter shall be included as an Exhibit.*)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section shall summarize the statements made by the provider or supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in "Other Applicable Authorities." It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [Contractor Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [Contractor Name]'s development request. As a result, [Contractor Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [Contractor Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)([1-8]) was appropriately implemented.)

This is an **UNFAVORABLE DETERMINATION**. [Contractor name] concludes that there was no error made in the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As a result, [Provider/Supplier Name]'s Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]

[Contractor Name]

10.7.14 – Model Opt-out Letters

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

Instruction

The Contractors shall use the model letters in this section to respond to eligible practitioners' opt-out affidavits, request additional documentation, approve opt-out affidavits and acknowledge the cancelation, or early termination of an opt-out. The Contractors shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The Contractors may issue the Model Opt-out Development Letter via fax, e-mail, or mail to the eligible practitioner.

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

A. Opt-out Affidavit Development Letter

*(*MACs shall use the following letter to request missing information from an eligible practitioner that wishes to opt-out of Medicare. This letter should be sent only one time and include a request for all missing information. The MAC may select the response type, either via mail, fax or email.*)*

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: *[*Case/Control Number*]*

Dear [Eligible Practitioner]:

[MAC] requires the following information to complete the processing of your Medicare opt-out affidavit:

- [Specify information needed]

Submit the requested information within 30 calendar days of the postmark date of this letter [to the address listed below, via fax to (###-###-####), or via email to *[*enter PE analyst's email address here*]*]. We may reject your opt-out affidavit if you do not furnish the requested information within this timeframe.

[Name of MAC]
[Address]
[City], [ST] [Zip]

Attach a copy of this letter with your revised opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] .

Sincerely,

[Name]
[Title]
[Company]

B. Opt-out Rejection Letter

*(*If an eligible practitioner does not respond timely or does not respond with needed information to complete an opt-out affidavit, the MACs shall issue this rejection letter.*)*

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] [ST] [Zip]

Reference: *[*Case/Control Number*]*

Dear *[*Eligible Practitioner Name*]*:

[MAC] is rejecting your Medicare opt-out affidavit, received on [insert date], for the following reason(s):

- [List all reasons for rejection]

To resubmit your opt-out affidavit include all information needed to process your opt-out request. Additional information on submitting a complete opt-out affidavit can be found at: [enter MAC website address].

Resubmit your completed opt-out affidavit to:
[Name of MAC]
[Address]
[City], [ST] [Zip]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

C. Opt-out Return Letters

Opt-out affidavits should only be returned for the following reasons:

1. The eligible practitioner requesting to opt-out of Medicare is not appropriately licensed by the state*;*

2. The practitioner is a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.);
3. The opt-out affidavit is filed with an incorrect MAC;
4. The eligible practitioner decides not to opt out of Medicare while their opt-out affidavit is still in process, but not yet approved by the MAC;
5. The eligible practitioner submits a cancellation request too late (within 30 days of the auto-renewal date or after the auto-renewal date). This return letter provides appeal rights; or
6. The eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date.

MACs shall issue the specific letter for the return reason.

1. Opt-out Return Letter – Unlicensed Eligible Practitioner

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] /ST/ [Zip]

Reference: /Case/Control Number/ *(optional)*
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], as you are not licensed by the state for the specialty type you indicated on your opt-out affidavit. For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

2. Opt-out Return Letter – Ineligible Practitioner

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] /ST/ [Zip]

Reference: /Case/Control Number/
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you indicated a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.) of Medicare.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

3. Opt-out Return Letter – Submitted to Incorrect MAC

[month] [day], [year]

[Eligible Practitioner Name]
[Address]
[City] /ST/ [Zip]

Reference: /Case/Control Number/
NPI: /xxxxxxxxxx/

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because your opt-out affidavit was filed with an incorrect Medicare Administrative Contractor for the state that you are located in. Your affidavit should be resubmitted to the appropriate contractor for processing.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

4. Opt-out Return Letter – Withdraw of Affidavit During Processing

[month] [day], [year]
[Eligible Practitioner Name]
[Address]
[City] /ST/ [Zip]

Reference: /Case/Control Number/
NPI: /xxxxxxxxxx/

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,
[Name]
[Title]
[Company]

5. Opt-out Return Letter – Late Cancellation Request

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

We Can't Cancel Your Medicare Opt-Out Status

Dear [Eligible Practitioner Name]:

We can't cancel the automatic renewal of your Medicare opt-out status because we didn't get your cancellation request in time. Your opt-out status automatically renewed for 2 years on [Month] [DD], [YYYY].

To properly cancel your opt-out status, you needed to submit your request by [Month] [DD], [YYYY], which was at least 30 days before your automatic opt-out renewal. [Contractor Name] is returning your written request, which they got on [Month] [DD], [YYYY].

Next Steps

If you don't request reconsideration, your next chance to cancel the automatic renewal of your Medicare opt-out status is prior to [Month] [DD], [YYYY] for the renewal that will occur on [Month] [DD], [YYYY].

If you believe you submitted a proper cancellation request before [Month] [DD], [YYYY], you can submit a reconsideration request to appeal the determination that you didn't timely or properly cancel your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't cancel your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations in 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to cancel your opt-out status.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Opt-out Return Letter – Cancellation Request Submitted Too Early

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Contractor Name] is returning your written request to cancel the automatic renewal your Medicare opt-out status, submitted on [Month] [DD], [YYYY], as it was submitted at more than 90 days prior to the end of your current opt-out period.

Please submit your cancellation request no later than 30 days prior to the end of your current opt-out period to avoid auto-renewal of your opt-out status. *The end of your current opt-out period* is: [Month] [DD], [YYYY].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

D. Opt-out Affidavit Approval Letters

The Contractors shall issue an Opt-out Affidavit Approval model letter when approving an opt-out affidavit and PECOS has been updated with the affidavit information. The approval letter shall be issued for the following reasons:

1. Approved Opt-Out, Eligible Practitioner May Order & Refer
2. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (OIG Exclusion)
3. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Ineligible Specialty)
4. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Did Not Elect to Order & Refer)
5. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)
6. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner has Revoked Billing Privileges)
7. Approved Opt-Out Change of Information

The Opt-out approval letter shall include:

- The eligible practitioner's personal information:
  - Name,
  - Address,
  - NPI,

    - Specialty, and
    - Eligibility to order and refer.

- The eligible practitioner's opt-out effective date.

- The date that the eligible practitioner can submit a request to cancel their opt-out affidavit (at least 30 days prior to the end-date of their current opt-out period).

- The date the eligible practitioner can terminate his/her/their opt-out early (if they are eligible to so, no later than 90 days after the effective date) of the eligible practitioner's initial 2-year opt-out period.

- Should the eligible practitioner opt-out a subsequent time after cancelling, contractors shall remove the paragraph noting "Since you are opting out for the very first time…" since this statement no longer applies.

1. Opt-out Affidavit Approval Letter – Eligible Practitioner Approved to Order & Refer

[Month] [DD], [YYYY]
[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

You've Successfully Opted Out of Medicare

Opt-out Affidavit Information:

Practitioner Name:	[Name]
Address:	[Address, City, State, Zip]
NPI:	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You're eligible to Order and Refer
Effective Date:	[Effective date]

[Contractor Name] approved your Medicare opt-out affidavit. **You don't need to take additional action at this time.** However, since you're opting out of Medicare for the first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate your opt-out status during this 90-day period, submit your written request by [Month] [DD], [YYYY]. After this 90-day period ends, you can cancel your opt-out status at the end of the 2 year opt-out period only. Your opt-out status will automatically renew every 2 years.

To cancel your opt-out status, submit written cancellation request at least 30 days before the end of the opt-out period. For example, if you decide you want to cancel your opt-out status at the end of this opt-out period, submit your cancellation request by [Month] [DD], [YYYY].

If you believe you submitted a proper termination request within 90 days of the effective date above, you can submit a reconsideration request. A reconsideration request allows you to appeal the determination that you didn't timely and properly terminate your opt-out status.

CMS (or a contractor) will review your request to see if we made an error in determining that you didn't terminate your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to terminate your opt-out status. **You may submit a reconsideration request by [Month] [DD], [YYYY] (65 days after the 90-day termination period ends).).**

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing by the date indicated above and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,
[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Excluded by the OIG)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You have been excluded by the OIG (and even if you have or have not obtained a waiver according to 42 C.F.R. § 1001.1901(c)), you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request sections below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of

this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Ineligible Specialty)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as your specialty is ineligible to order and refer.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request,

please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Did Not Elect to Order and Refer)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries as you did not elect to be and ordering and referring practitioner on your opt-out affidavit.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[Not Provided]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have not obtained an NPI.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Has Revoked Billing Privileges)

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] approved your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You are not eligible to Order and Refer*
Effective Date:	[Effective date]

* Your billing privileges have been revoked, you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90-day period to change your mind about opting out. If you decide to terminate during this 90-day period, you must submit your request, in writing, no later than [Month] [DD], [YYYY]. After this 90-day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90-day period ends. Please follow the Right to Submit a Reconsideration Request section below.

To cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

7. Opt-out Affidavit Approval Letter – Approved Opt-Out Change of Information

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)

Dear [Eligible Practitioner Name]:

[Insert Contractor] has updated your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name:	[Name]
Address on File:	[Address, City, State, Zip]
National Provider Identifier (NPI):	[NPI]
Specialty:	[Specialty]
Ordering and Referring:	You [are/are not] eligible to Order and Refer[*]
Effective Date:	[Effective date]
Changed Information:	

[* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have {enter reason for inability to order and refer}.]

As a reminder, to cancel opt-out, you must submit a cancellation request at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month] [DD], [YYYY].

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. Opt-out Renewal Alert Letter

(The contractor shall issue the following letter to inform the eligible practitioner that the opt-out is due to be automatically renewed.)

[Month] [DD], [YYYY]
[Eligible Practitioner Name]
[Address from which opt-out was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Action Needed to Cancel Your Medicare Opt-Out Status

Dear [Eligible Practitioner Name]:

Your Medicare opt-out status will be automatically renewed for a new 2-year opt-out period on [Month] [DD], [YYYY]. You don't need to take additional action at this time.

However, if you would like to cancel your opt-out status, submit a written cancellation request by [Month] [DD], [YYYY], which is at least 30 days before the end of your current opt-out period.

If you believe you submitted a proper cancellation request by [Month] [DD], [YYYY], you can submit a reconsideration request. A reconsideration request allows you to appeal the determination that you didn't timely and properly terminate your opt-out status. CMS (or a contractor) will review your request to see if we made an error in determining that you didn't cancel your opt-out status in a proper or timely manner. We'll base this decision on the information you include in your reconsideration request, CMS and contractor documents, and applicable regulations 42 C.F.R. §§ 405.400-405.455. Submitting a reconsideration request doesn't allow you to submit (or allow us to accept) an untimely request to cancel your opt-out status. **You may submit a reconsideration request by [Month] [DD], [YYYY] (65 days after the last day to cancel the current opt-out period).**

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must--

- Be received in writing by the date indicated above and mailed or emailed to the address below.
- 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/she/they have 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; and
    - Authorized or delegated officials for groups cannot sign and submit a 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/their 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; and
- Include an email address if you want to receive correspondence regarding your appeal via email.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: ([Contractor email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

F. Opt-out Affidavit Termination Letter

*(*If an eligible practitioner timely terminates his/her/their initial opt-out, the Contractors shall acknowledge this action by using this model letter.*)*

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which request was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Insert Contractor] completed your request to terminate your Medicare opt-out affidavit.

Want to enroll as a Medicare billing provider or for the sole purpose of ordering and referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

G. Opt-out Affidavit Cancellation Letter

*(*If an eligible practitioner timely submits an opt-out cancellation request, the Contractors shall acknowledge this action by using this model letter.*)*

[Month] [DD], [YYYY]

[Eligible Practitioner Name]
[Address from which request was sent]
[City], [ST] [Zip]

Reference: [Case/Control Number] (optional)
NPI: [xxxxxxxxxx]

Dear [Eligible Practitioner Name]:

[Contractor Name] completed your request to cancel your Medicare opt-out affidavit.

Your opt-out status will be canceled effective [Month] [DD], [YYYY].

Want to enroll as a Medicare billing provider or for the sole purpose of ordering of referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the implementation of the initial determination. (Optional Coversheet sentence) [To facilitate the processing of your reconsideration request, please utilize and include the attached coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- 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/she/they have 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/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their 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.

Failure to submit a reconsideration request is deemed a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

[Contractor Name]
[Address]
[City], [ST] [Zip]

Or emailed to: [Contractor appeal email].

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

10.7.20 – Stay of Enrollment Letters

(Rev. 13085; Issued: 03-13-25; Effective: 05-13-25; Implementation: 05-13-25)

This section 10.7.20 contains letters that contractors shall use in stay of enrollment situations. Note that the contractor may remove language from the letter that obviously does not apply to the provider/supplier type in question (e.g., reassignment language in a letter pertaining to an HHA under a stay).

A. Imposition of Stay of Enrollment Notification Letter – Revalidation Non-Response

Stay of Enrollment

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Pursuant to 42 CFR § 424.541, we are placing a stay on your Medicare enrollment record effective [insert day of letter's issuance] because you have not responded to our revalidation request of [date revalidation request letter sent]. Your revalidation was due on [insert date].

During this stay, claims for services and items you furnish during this period will be rejected. However, this does not affect your Medicare participation agreement or any of its conditions, and you remain enrolled in the Medicare program.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. Failure to submit a revalidation application within 30 days of this notice may

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

What record needs revalidating

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

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

The CMS lists the records that need revalidating at:

go.cms.gov/MedicareRevalidation

How to resume your payments:

- **Revalidate your Medicare enrollment record**, through https://pecos.cms.hhs.gov/pecos/login.do or [Form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484- 8049.

- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

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

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the stay of enrollment as indicated in 42 C.F.R. § 424.541(b). The rebuttal must be received in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this stay of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) Authorized or delegated officials for groups cannot sign and submit a rebuttal 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/their behalf.

If the provider/supplier wishes to appoint a legal representative who is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing

the legal representative to act on the provider's or supplier's behalf. The notice should be signed by the provider/supplier.

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

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

The provider's or supplier's failure to submit a rebuttal that is both timely and fully compliant with all of the requirements above constitutes a waiver of all rebuttal rights. The rebuttal should be sent to the following:

[Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

OR, as applicable

Name and address of MAC]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

If you need help

Visit **go.cms.gov/MedicareRevalidation**

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

Sincerely,

[Name]
[Title]
[Company]

B. Imposition of Stay Notification Letter – All Situations Other than Section 10.7.20(A)

Stay of Enrollment

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Pursuant to 42 CFR § 424.541, we are placing a stay on your Medicare enrollment record effective [day of letter's issuance] because [provide explanation, such as "you did not

report a new managing employee within 30 days of the change as required under 42 CFR § 424.516 (or 42 CFR § 424.57(c)(2) for DMEPOS suppliers)" or "your current ownership information on file with Medicare is incorrect"].

> [Example of supporting facts and rationale: [ABC, Inc.'s Medicare 855 enrollment record reflects that Jane Doe is the owner, authorized official, director and managing employee of Argo Medical Supplies & Services, Inc. However, CMS has found information on the New York Secretary of State which reveals that John Doe is listed as manager effective October 11, 2023. A manager (which meets the definition of managing employee, per 42 C.F.R. § 424.502) is required to be reported on the 855S enrollment record.]]

During this stay, claims for services and items you furnish during this period will be rejected. However, this does not affect your Medicare participation agreement or any of its conditions, and you remain enrolled in the Medicare program.

[In order to maintain enrollment in the Medicare program, you must submit a CMS 855 Change of Information Application. Failure to do so by [today's date + 30] may result in a deactivation or revocation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs to be updated.

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

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

How to resume your payments:

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

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

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the stay of enrollment as indicated in 42 C.F.R. § 424.541(b). The rebuttal must be received in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this stay of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a

DMEPOS supplier's enrollment.) Authorized or delegated officials for groups cannot sign and submit a rebuttal 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/their behalf.

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

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

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

The provider's or supplier's failure to submit a rebuttal that is both timely and fully compliant with all of the requirements above constitutes a waiver of all rebuttal rights.

The rebuttal should be sent to the following:

[Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Boulevard
Mailstop: AR-19-51
Baltimore, MD 21244-1850

OR, as applicable

Name and address of MAC]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Name]
[Title]
[Company]

C. Stay of Enrollment Rebuttal Model Letters

Instruction

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

1. Rebuttal Further Information Required Development Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal

submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Optional)

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

On [Month] [DD]. [YYYY], [Contractor Name] issued a favorable rebuttal determination, reversing the stay of [Provider/Supplier Name]'s Medicare enrollment and billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reinstatement of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation] (lists of 3 or more items should be in a bulleted list). Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

2. Rebuttal Facts or Issues and Reasons for Disagreement Development Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541. We received your rebuttal submission on [Month] [DD], [YYYY].

As stated in the stay of enrollment letter dated [Month] [DD], [YYYY], and 42 C.F.R. § 424.541(b), to be accepted and reviewed, your rebuttal must state the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. The rebuttal received on [Month] [DD], [YYYY] does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [Contractor Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper rebuttal that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised rebuttal submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

Please send the required documentation to:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
Fax: [Contractor Rebuttal Receipt Fax Number]

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(4).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. Rebuttal Withdrawn Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Withdrawal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

We are in receipt of your written request to withdraw your rebuttal received on [Month] [DD], [YYYY], submitted in response the stay of [Provider/Supplier]'s enrollment. [Contractor Name] has not yet issued a rebuttal determination. Therefore, [Contractor Name] considers the rebuttal to be withdrawn. As a result, a determination will not be issued in response to the rebuttal and [Provider/Supplier Name]'s Medicare enrollment will remain subject to a stay of enrollment imposed under 42 C.F.R. § 424.541.

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under § 424.541(b)(4).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. Rebuttal Receipt Acknowledgement Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

On [Month] [DD], [YYYY] we received your rebuttal regarding the stay of [Provider/Supplier Name]'s enrollment. They stay of enrollment was imposed by letter dated [Month] [DD], [YYYY]. [Contractor Name] will further review the information and documentation submitted in the rebuttal and will render a final determination regarding the stay of enrollment within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. Final Rebuttal Decision Email Template - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

***To:** [Email address provided by the person who submitted the rebuttal and email address listed in the provider/supplier correspondence mailing address on the enrollment application if different from the email address on the rebuttal submission.]*

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

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

Please see the attached determination regarding your rebuttal, in response to the stay of [Provider/Supplier Name]'s enrollment.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Rebuttal Dismissal Model Letters - Stay of Enrollment

A. Untimely Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal as it was not timely submitted. The stay of enrollment letter was dated [Month] [DD], [YYYY]. Pursuant to 42 C.F.R. § 424.541(b)(1), a rebuttal must be received within 15 calendar days of the date of the stay of enrollment letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You failed to show good cause for the late request. Therefore, [Contractor Name] is unable to render a determination in this matter and the stay of enrollment will not be modified.

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(4).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

B. Improper Signature Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal because it did not contain any of the following:

1. *Signature by an authorized or delegated official currently on file in [Provider/Supplier]'s Medicare enrollment, the individual practitioner or a legal representative;*
2. *The required statement of representation from an attorney;*
3. *Signed written notice appointing a non-attorney legal representative.*

Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned practitioner without a signed statement authorizing that individual from the group to act on the practitioner's behalf.

The signature requirement is stated in the [Month] [DD], [YYYY] stay of enrollment letter, and in 42 C.F.R. § 424.541(b)(3)(iv). Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you provide a properly signed rebuttal and permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15 calendar days. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/CT/MT/PT] and [x:00 a.m./p.m ET/CT/MT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

C. No Rebuttal Rights Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email

address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Submission Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name] on [Month] [DD], [YYYY], submitted on behalf of [Provider/Supplier Name].

[Contractor Name] is unable to accept your rebuttal submission because the action taken in regard to [Provider/Supplier]'s Medicare enrollment or billing privileges does not afford the opportunity for a rebuttal. Only a provider/supplier whose enrollment is stayed under 42 C.F.R. § 424.541, or whose billing privileges are deactivated under § 424.540 may file a rebuttal. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

D. More than One Submission Rebuttal Dismissal Model Letter - Stay of Enrollment

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submissions
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10.4.9.1(A) of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per stay of enrollment letter. Therefore, [Contractor Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY] (list all additional dates if applicable). As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

E. No Specification of Why the Provider/Supplier Disagrees with Enrollment Stay and Reasons for Disagreement Rebuttal Dismissal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], in response to the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal as it does not specify the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. The requirement to identify the facts or issues with which you disagree and your reasons for disagreement was stated in the stay of enrollment letter, dated [Month] [DD], [YYYY], in 42 C.F.R. § 424.541(b)(3), and in Chapter 10 of the Medicare Program Integrity Manual. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you identify the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. This letter permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(3).

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

7. Stay of Enrollment Rebuttal Not Actionable (Moot) Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

On [Month] [DD], [YYYY], [Contractor Name] reviewed the stay of enrollment for [Provider/Supplier Name] and [revised imposition letter (OR) lifted the stay]. The [revised imposition letter (OR) rescission letter (OR) letter lifting the stay], dated [Month] [DD], [YYYY], rendered the issue set forth in your rebuttal no longer actionable. For your convenience a copy of the [revised imposition letter (OR) rescission letter (OR) letter lifting the stay] is attached. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

(The contractor shall include PDF copy of the letter that rendered the rebuttal moot (e.g. the revised imposition letter or rescission letter.)

8. Favorable Stay of Enrollment Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name] based on the stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541. (If the rebuttal was timely, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD],

[YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

APPLICABLE AUTHORITIES: *(list any authorities cited in analysis)*

- *42 C.F.R. § 424.541*
- *[enrollment requirement that led to stay]*
- *Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable)*

EXHIBITS:

- *Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);*
- *Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, imposing a stay of Home Healthcare Services, LLC's Medicare enrollment pursuant to § 424.541).*

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, as well as a brief description of the document. The contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The stay of enrollment letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether the imposition of the stay and/or the effective date of the stay are correct. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in the "Applicable Authorities" section above. At a minimum, the review shall consist of whether the supplier was non-complaint and whether the non-compliance can be remedy by submitted the applicable CMS form, as well as the effective date of the stay. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] notified Home Healthcare Services, LLC of the [Month] [DD], [YYYY] deadline to revalidate its Medicare enrollment. On [Month] [DD], [YYYY], [Contractor Name] imposed a stay of Home Healthcare Services, LLC's enrollment. However, [Contractor Name] received a revalidation on [Month] [DD], [YYYY]. Therefore, Home Healthcare Services, LLC was in compliance with the revalidation

requirement. As a result, [Contractor Name] finds that the stay of Home Healthcare Services, LLC's Medicare enrollment was not correct.)

*This is a **FAVORABLE DETERMINATION**. To effectuate this determination, [Contractor name] will remove the stay and reinstate [Provider/Supplier Name]'s Medicare enrollment.*

(If additional information is needed from the provider/supplier in order to reinstate the enrollment, the Contractor shall state what information is needed from the provider or supplier in this rebuttal determination. Contractors shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

9. Unfavorable Stay of Enrollment Rebuttal Model Letter

(To be sent by hard-copy mail, and via email if email address is provided with the rebuttal submission, and email address listed in the provider/supplier correspondence mailing address on the enrollment application or enrollment record if different from the email address on the rebuttal submission. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (optional)

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

This letter is in response to the rebuttal received by [Contractor Name] based on the stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541. (If the rebuttal was timely, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.]) [Contractor Name] based the following determination on the Social Security Act (Act),

Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

APPLICABLE AUTHORITIES: *(list any authorities cited in analysis)*

- *42 C.F.R. § 424.541*
- *[enrollment requirement that led to stay]*
- *Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable)*

EXHIBITS:

- *Exhibit 1: (Example: Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);*
- *Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, imposing a stay of Home Healthcare Services, LLC's Medicare enrollment pursuant to § 424.541).*

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, as well as a brief description of the document. The Contractor shall also include other documentation not submitted by the provider or supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The stay of enrollment letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether the imposition of the stay and/or the effective date of the stay are correct. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in the "Applicable Authorities" section above. At a minimum, the review shall consist of whether the supplier was non-complaint and whether the non-compliance can be remedy by submitted the applicable CMS form, and the effective date of the stay. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [Contractor Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [Contractor Name]'s development request. [Contractor Name] properly rejected Home Healthcare Services, LLC's revalidation application. As a result, Home Healthcare Services, LLC was non-compliant with the revalidation requirement. Therefore, [Contractor Name]

finds that the stay of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.541 was appropriately implemented.)

*This is an **UNFAVORABLE DETERMINATION**. [Contractor name] concludes that there was no error made in the stay of [Provider/Supplier Name]'s Medicare enrollment. As a result, **the stay of [Provider/Supplier Name]'s enrollment remains intact**. During this stay, claims for services and items [Provider/Supplier Name] furnishes during this period will be rejected. However, this does not affect [Provider/Supplier Name]'s Medicare participation agreement or any of its conditions, and [Provider/Supplier Name] remains enrolled in the Medicare program.*

NEXT STEPS:

Failure to (choose applicable requirement that led to stay of enrollment) [timely revalidate your Medicare enrollment (OR) timely submit a Change of Information application] may result in a deactivation or revocation of your Medicare enrollment. If you are a non-certified provider/supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]