§ 405.874 Appeals of CMS or a CMS contractor.

A CMS contractor’s (that is, a carrier, Fiscal Intermediary or Medicare Administrative Contractor (MAC)) determination that a provider or supplier fails to meet the requirements for Medicare billing privileges.

(a) Denial of a provider or supplier enrollment application. If CMS or a CMS contractor denies a provider’s or supplier’s enrollment application, CMS or the CMS contractor must notify the provider or supplier by certified mail. The notice must include the following:

(1) The reason for the denial in sufficient detail to allow the provider or supplier to understand the nature of its deficiencies.
(2) The right to appeal in accordance with part 498 of this chapter.
(3) The address to which the written appeal must be mailed.

(b) Revocation of Medicare billing privileges—(1) Notice of revocation. If CMS or a CMS contractor revokes a provider’s or supplier’s Medicare billing privileges, CMS or a CMS contractor must notify the supplier by certified mail. The notice must include the following:

(i) The reason for the revocation in sufficient detail for the provider or supplier to understand the nature of its deficiencies.
(ii) The right to appeal in accordance with part 498 of this chapter.
(iii) The address to which the written appeal must be mailed.

(2) Effective date of revocation. The revocation of a provider’s or supplier’s billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

(3) Payment after revocation. Medicare does not pay and the CMS contractor rejects claims for services submitted with a service date on or after the effective date of a provider’s or supplier’s revocation.

(c) Appeal rights. (1) A provider or supplier may appeal the initial determination to deny a provider or supplier’s enrollment application, or if applicable, to revoke current billing privileges by following the procedures specified in part 498 of this chapter.
(2) The reconsideration of a determination to deny or revoke a provider or supplier’s Medicare billing privileges will be handled by a CMS Regional Office or a contractor hearing officer not involved in the initial determination.
(3) Providers and suppliers have the opportunity to submit evidence related to the enrollment action. Providers and suppliers must, at the time of their request, submit all evidence that they want to be considered.
(4) If supporting evidence is not submitted with the appeal request, the contractor contacts the provider or supplier to try to obtain the evidence.
(5) If the provider or supplier fails to submit this evidence before the contractor issues its decision, the provider or supplier is precluded from introducing new evidence at higher levels of the appeals process.

(d) Impact of reversal of contractor determinations on claims processing. (1) Claims for services furnished to Medicare beneficiaries during a period in which the supplier billing privileges were not effective are rejected.
(2) If a supplier is determined not to have qualified for billing privileges in one period but qualified in another, Medicare contractors process claims for services furnished to beneficiaries during the period for which the supplier was Medicare-qualified. Subpart C of this part sets forth the requirements for the recovery of overpayments.
(3) If a revocation of a supplier’s billing privilege is reversed upon appeal, the supplier’s billing privileges are reinstated back to the date that the revocation became effective.

(4) If the denial of a supplier’s billing privileges is reversed upon appeal and becomes binding, then the appeal decision establishes the date that the supplier’s billing privileges become effective.

(e) Reinstatement of provider or supplier billing privileges following corrective action. If a provider or supplier completes a corrective action plan and provides sufficient evidence to the CMS contractor that it has complied fully with the Medicare requirements, the CMS contractor may reinstate the provider’s or supplier’s billing privileges. The CMS contractor may pay for services furnished on or after the effective date of the reinstatement. The effective date is based on the date the provider or supplier is in compliance with all Medicare requirements. A CMS contractor’s refusal to reinstate a supplier’s billing privileges based on a corrective action plan is not an initial determination under part 498 of this chapter.

(f) Effective date for DMEPOS supplier’s billing privileges. If a CMS contractor, contractor hearing officer, or ALJ determines that a DMEPOS supplier’s denied enrollment application meets the standards in §424.57 of this chapter and any other requirements that may apply, the determination establishes the effective date of the billing privileges as not earlier than the date the carrier made the determination to deny the DMEPOS supplier’s enrollment application. Claims are rejected for services furnished before that effective date.

(g) Submission of claims. A provider or supplier succeeding in having its enrollment application denial or billing privileges revocation reversed in a binding decision, or in having its billing privileges reinstated, may submit claims to the CMS contractor for services furnished during periods of Medicare qualification, subject to the limitations in §424.44 of this chapter, regarding the timely filing of claims. If the claims previously were filed timely but were rejected, they are considered filed timely upon resubmission. Previously denied claims for items or services rendered during a period of denial or revocation may be resubmitted to CMS within 1 year after the date of reinstatement or reversal.

(h) Deadline for processing provider enrollment initial determinations. Contractors approve or deny complete provider or supplier enrollment applications to approval or denial within the following timeframes:

(1) Initial enrollments. Contractors process new enrollment applications within 180 days of receipt.

(2) Revalidation of existing enrollments. Contractors process revalidations within 180 days of receipt.

(3) Change-of-information and reassignment of payment request. Contractors process change-of-information and reassignment of payment requests within 90 days of receipt.

[73 FR 36460, June 27, 2008, as amended at 73 FR 69932, Nov. 19, 2008]