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Only One Short Bite of the Apple: Change in the Medicare Enrollment Appeals Process [Ober|Kaler]

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In keeping with the trend to strengthen its authority to deny an enrollment or revoke Medicare billing privileges, CMS has modified the appeals process in a manner that will significantly shorten the time allotted to mount an effective appeal. In Transmittal 609 [PDF], CMS announced several changes to Chapter 15 of the Medicare Program Integrity Manual (MPIM) which will be effective on November 2, 2015. CMS described these as "several minor revisions"; however, the changes to the appeals process are rather significant.

Before explaining the changes in Transmittal 609, it is important to understand the distinctions in the regulations for claims appeals versus enrollment appeals. The number of steps in the process and the timing for filing appeals are different for the two types of appeals. The chart below provides an overview of the *current* administrative appeals process for claims and enrollment decisions.

Claims Appeals	Enrollment Appeals
Redeterminations – 120 days to appeal.	No corresponding level of appeal.
Reconsideration – 180 days to appeal, with ability to supplement the record until the reconsideration decision is issued.	Reconsideration – 60 days to appeal.
ALJ Hearing Request – 60 days to appeal. Only able to supplement the record if the ALJ finds "good cause" as defined by the regulations.	ALJ Hearing Request – 60 days to appeal but currently able to supplement the record at the time of requesting a hearing.

Under the *revised* policy for enrollment appeals, CMS has removed the ability to supplement the record at the ALJ level of appeal absent a "good cause" finding. Essentially, the provider's only opportunity to submit information to be considered at either level of appeal is to submit it *with* the request for reconsideration. The

provider does not even have the opportunity to supplement the request prior to the issuance of a reconsideration decision. Compared to the nearly one-year time period to gather evidence and develop factual and legal arguments in a claims appeal, a provider has a grand total of 60 days to do so following an enrollment denial or billing privilege revocation.

Ober|Kaler's Comments

It is important to ensure that there are current addresses in PECOS, the Medicare enrollment data base, and that contact persons are aware of the need to timely review all correspondence from the Medicare Administrative Contractor. Since time to submit evidence in appeals of enrollment denials or revocations of billing privileges is limited, decisions need to be made quickly regarding how best to gather evidence, develop facts to refute the determination, and explore legal arguments.