CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 354	Date: August 27, 2010
	Change Request 7016

SUBJECT: Manual Redesign

I. SUMMARY OF CHANGES: CMS will reorganize and move information contained in chapter 10, to chapter 15. In addition, CMS will incorporate a limited number of changes to these sections. This change request will organize the sections into more manageable content units that will be easily understood by the providers and suppliers.

EFFECTIVE DATE: September 28, 2010
IMPLEMENTATION DATE: September 28, 2010

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.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	10/2.9/Timeliness and Accuracy Standards
D	10/2.9.1/Standards for Initial Applications
D	10/2.9.1.1/Paper Applications - Timeliness
D	10/2.9.1.1.1/CMS-855A Applications
D	10/2.9.1.1.2/CMS-855I Applications
D	10/2.9.1.1.3/CMS-855B Applications Submitted by Suppliers Other Than IDTFs
D	10/2.9.1.1.4/CMS-855B Applications Submitted by IDTFs
D	10/2.9.1.2/Paper Applications - Accuracy
D	10/2.9.1.3/Web-Based Applications - Timeliness
D	10/2.9.1.4/Web-Based Applications - Accuracy
D	10/2.9.2/Standards for Changes of Information
D	10/2.9.2.1/Paper Applications - Timeliness
D	10/2.9.2.2/Paper Applications - Accuracy
D	10/2.9.2.3/Web-Based Applications - Timeliness
D	10/2.9.2.4/Web-Based Applications - Accuracy
D	10/2.9.3/General Timeliness Principles

D	10/9/Revalidation
D	10/9.1/Supplementary Revalidation Activities
D	10/13/Provider Enrollment Disenrollment Actions
D	10/13.1/CMS or Contractor Issued Deactivations
D	10/13.2/Contractor Issued Revocations
D	10/13.2.1/Revocations Involving Certified Suppliers and Providers
D	10/13.3/DPSE Issued Revocations
D	10/13.3.1/PSC Identified Revocations
D	10/13.3.2/CMS Satellite Office or Regional Office Identified Revocations
D	10/13.4/External Reporting Requirements
D	10/14/14.21/Model Approval Letter for Providers Who Order and Refer Only
D	10/22/Site Verifications
D	10/22.1/Site Verifications to Determine Operational Status
D	10/22.2/Site Verifications to Determine if a Provider or Supplier Meets or Continues to Meet the Regulatory Requirements for Their Provider or Supplier Type
D	10/22.3/National Supplier Clearinghouse (NSC)
N	15/4.4.2.8/Intensive Cardiac Rehabilitation (ICR)
N	15/6/Timeliness and Accuracy Standards
N	15/6.1/Standards for Initial Applications
N	15/6.1.1/Paper Applications - Timeliness
N	15/6.1.1.1/CMS-855A Applications
N	15/6.1.1.2/CMS-855I Applications
N	15/6.1.1.3/CMS-855B Applications Submitted by Suppliers Other Than IDTFs
N	15/6.1.1.4/CMS-855B Applications Submitted by IDTFs
N	15/6.1.2/Paper Applications - Accuracy
N	15/6.1.3/Web-Based Applications - Timeliness
N	15/6.1.4/Web-Based Applications - Accuracy
N	15/6.2/Standards for Changes of Information
N	15/6.2.1/Paper Applications - Timeliness
N	15/6.2.2/Paper Applications - Accuracy
N	15/6.2.3/Web-Based Applications - Timeliness
N	15/6.2.4/Web-Based Applications - Accuracy
N	15/6.3/General Timeliness Principles
N	15/18/Initial Enrollment Determination
N	15/20/Onsite Inspections and Site Verifications
N	15/20.1/Site Verifications to Determine Operational Status

N	15/20.2/Site Verifications to Determine if a Provider or Supplier Meets or Continues to Meet the Regulatory Requirements for Their Provider or Supplier Type
N	15/20.3/National Supplier Clearinghouse (NSC)
N	15/24.21/Model Approval Letter for Providers Who Order and Refer Only
N	15/27/Deactivations and Revocations
N	15/27.1/CMS or Contractor Issued Deactivations
N	15/27.2/Contractor Issued Revocations
N	15/27.2.1/Revocations Involving Certified Suppliers and Providers
N	15/27.3/DPSE Issued Revocations
N	15/27.3.1/PSC Identified Revocations
N	15/27.3.2/CMS Satellite Office or Regional Office Identified Revocations
N	15/27.4/External Reporting Requirements
N	15/29/Provider and Supplier Revalidations and DMEPOS Re-enrollment
N	15/29.1/Supplementary Revalidation Activities

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 354	Date: August 27, 2010	Change Request: 7016

SUBJECT: Manual Redesign

EFFECTIVE DATE: September 28, 2010
IMPLEMENTATION DATE: September 28, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) will reorganize and move the information contained in chapter 10 to chapter 15. In addition, CMS will incorporate a limited number of changes to these sections (see business requirements below). This change request will organize the sections into more manageable content units that will be easily understood by the providers and suppliers.

B. Policy: There are no changes in CMS policy other than those contained in the business requirements and corresponding manual change.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7016.1	Medicare contractors shall use contents of chapter 15 in lieu of chapter. 10.	X	X	X	X	X					NSC
7016.2	When applying a 1 year enrollment bar, contractors shall refer to Pub. 100-08, chapter. 15, section 27.2 D, and use the corresponding AR code 73.	X			X						
7016.3	When applying a 2 year enrollment bar, contractors shall refer to Pub. 100-08, chapter 15, section 27.2 D, and use the corresponding AR code 74.	X			X						
7016.4	When applying a 3 year enrollment bar, contractors shall refer to Pub. 100-08, chapter. 15, section 27.2 D, and use the corresponding AR code 81.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s) for Ch. 15 Manual Redesign: Ann Marie Reimer (Vale) (410) 786-4898
Post-Implementation Contact(s) for Ch. 15 Manual Redesign: Ann Marie Reimer (Vale) (410) 786-4898

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev. 354, 08-27-10)

4.2.8 – Intensive Cardiac Rehabilitation (ICR)

6 - Timeliness and Accuracy Standard*s*
6.1 – Standards for Initial Application*s*
6.1.1 – Paper Applications - Timelines*s*
*6.*1.1.1 – CMS-855A Applications
*6.*1.1.2 – CMS-855I Applications
*6.*1.1.3 – CMS-855B Applications Submitted by Suppliers Other Than IDTFs
*6.*1.1.4 – CMS-855B Applications Submitted by IDTFs
6.1.2 – Paper Applications - Accuracy
*6.*1.3 – Web-Based Applications - Timelines*s*
*6.*1.4 – Web-Based Applications - Accurac*y*
*6.*2 – Standards for Changes of Informatio*n*
*6.*2.1 – Paper Applications - Timelines*s*
*6.*2.2 – Paper Applications - Accurac*y*
*6.*2.3 – Web-Based Applications - Timelines*s*
*6.*2.4 – Web-Based Applications - Accurac*y*
*6.*3 – General Timeliness Principle*s*

18 – Initial Enrollment Determination

2*0* – *Onsite Inspections and* Site Verifications
2*0*.1 – Site Verifications to Determine Operational Status
2*0*.2 – Site Verifications to Determine if a Provider or Supplier Meets or Continues to Meet the Regulatory Requirements for Their Provider or Supplier Type
2*0*.3 – National Supplier Clearinghouse (NSC)

*2*4.21 – Model Approval Letter for Providers Who Order and Refer Only

27 – Deactivations and Revocations
27.1 - CMS or Contractor Issued Deactivations
27.2 - Contractor Issued Revocations
27.2.1 - Revocations Involving Certified Suppliers and Providers
27.3 - DPSE Issued Revocations
27.3.1 - PSC Identified Revocations
27.3.2 - CMS Satellite Office or Regional Office Identified Revocations

27.4 - External Reporting Requirements
29 – *Provider and Supplier Revalidations and DMEPOS Re-enrollment*
29.1 – Supplementary Revalidation Activities

4.2.8 – Intensive Cardiac Rehabilitation (ICR)
(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

A. General Background Information

Effective January 1, 2010, Medicare Part B covers Intensive Cardiac Rehabilitation (ICR) program services for beneficiaries who have experienced one or more of the following:

- *An acute myocardial infarction within the preceding 12 months;*
- *A coronary artery bypass surgery;*
- *Current stable angina pectoris;*
- *Heart valve repair or replacement;*
- *Percutaneous transluminal coronary angioplasty or coronary stenting;*
- *A heart or heart-lung transplant.*

The ICR programs must be approved by CMS through the national coverage determination (NCD) process and must meet certain criteria for approval. Individual sites wishing to provide ICR services via an approved ICR program must enroll with their local Medicare contractor or MAC as an ICR program supplier.

B. ICR Enrollment

In order to enroll as an ICR site, a supplier must complete a Form CMS-855B, with the supplier type of "Other" selected. Contractors shall verify that the ICR program is approved by CMS through the NCD process. A list of approved ICR programs will be identified through the NCD listings, the CMS Web site and the Federal Register. Contractors shall use one of these options to verify that the ICR program has met CMS approval.

The ICR suppliers shall be enrolled using specialty code 31. ICR suppliers must separately enroll each of their practice locations. Therefore, each enrolling ICR supplier can only have one practice location on its CMS-855B enrollment application and shall receive its own PTAN.

Contractors shall only accept and process reassignments (855R's) to ICR suppliers for physicians defined in 1861(r)(1) of the Act.

C. Additional Information

For more information on ICR suppliers, refer to:

- *42 CFR §410.49;*

- *Pub. 100-04, chapter 32, sections 140.2.2 – 140.2.2.6 (Medicare Claims Processing Manual); and*

- *Pub. 100-02, chapter 15, sections 232 (Medicare Benefit Policy Manual)*

6 – Timeliness and Accuracy Standards

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

Sections *6*.1 through *6*.3 of this chapter address the timeliness and accuracy standards applicable to the processing of CMS-855 applications. Even though the provisions of 42 CFR § 405.874(h) contain processing timeframes that are longer than those in sections *6*.1 through *6*.3, the contractor shall adhere to the standards specified in sections *6*.1 through *6*.3.

The processing of an application generally includes, but is not limited to, the following activities:

- Receipt of the application in the contractor's mailroom and forwarding it to the appropriate office for review;

- Prescreening the application in accordance with section *7.*1 of this chapter;

- Creating an L & T record and an enrollment record in PECOS;

- Verification of the application in accordance with sections *8*.1 through *8.*7.1 of this chapter;

- Requesting and receiving clarifying information in accordance with section *8*.3 of this chapter;

- Site visit (if necessary);

- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial.

6.1 – Standards for Initial Applications

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

For purposes of sections *6.*1.1 through *6.*1.4 of this chapter, the term "initial applications" also includes:

1. CHOW, acquisition/merger, and consolidation applications submitted by the new owner;

2. "Complete" CMS-855 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in PECOS, (c) as part of a reactivation, or (d) as part of a revalidation. (See section *13*.1.1 of this manual for more information on the processing of "complete" applications.)

6.1.1 - Paper Applications - Timeliness

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

For purposes of sections 6.1.1.2 though 6.1.1.4 below, the term "development" has the same general meaning as that used in section 8.3 of this chapter – specifically, the need to contact the supplier for additional information. (A prescreening letter to the provider is considered to be the first developmental request.)

6.1.1.1 – CMS-855A Applications

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 80 percent of CMS-855A initial applications within 60 calendar days of receipt, process 90 percent of CMS-855A initial applications within 120 calendar days of receipt, and process 99 percent of CMS-855A initial applications within 180 calendar days of receipt.

6.1.1.2 – CMS-855I Applications

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 80 percent of all initial CMS-855I applications where no contractor development is needed within 60 calendar days of receipt, and 95 percent of such applications within 90 calendar days of receipt.

The contractor shall process 80 percent of all initial CMS-855I applications where one developmental request is made by the contractor within 90 calendar days of receipt, 90 percent of such applications within 120 calendar days of receipt, and 95 percent of such applications within 180 calendar days of receipt.

The contractor shall process 70 percent of all initial CMS-855I applications where at least two developmental requests are made by the contractor within 90 calendar days of receipt, 80 percent of such applications within 120 calendar days of receipt, and 90 percent of such applications within 180 calendar days of receipt.

6.1.1.3 – CMS-855B Applications Submitted by Suppliers Other Than IDTFs

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

(This section 6.1.1.3 applies only to initial CMS-855B applications submitted by suppliers other than IDTFs.)

The contractor shall process 80 percent of all initial CMS-855B applications where no contractor development is needed within 60 calendar days of receipt, and 95 percent of such applications within 90 calendar days of receipt.

The contractor shall process 80 percent of all initial CMS-855B applications where one developmental request is made by the contractor within 90 calendar days of receipt, 90 percent of such applications within 120 calendar days of receipt, and 95 percent of such applications within 180 calendar days of receipt.

The contractor shall process 70 percent of all initial CMS-855B applications where at least two developmental requests are made by the contractor within 90 calendar days of receipt, 80 percent of such applications within 120 calendar days of receipt, and 90 percent of such applications within 180 calendar days of receipt.

6.1.1.4 – CMS-855B Applications Submitted by IDTFs

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 70 percent of all initial IDTF CMS-855B applications where no contractor development is needed within 90 calendar days of receipt, 80 percent of such applications within 120 calendar days of receipt, and 95 percent of such applications within 180 calendar days of receipt.

The contractor shall process 65 percent of all initial IDTF CMS-855B applications where one developmental request is made by the contractor within 90 calendar days of receipt, 75 percent of such applications within 120 calendar days of receipt, and 90 percent of such applications within 180 calendar days of receipt.

The contractor shall process 60 percent of all initial IDTF CMS-855B applications where two or more developmental requests are made by the contractor within 90 calendar days of receipt, 70 percent of such applications within 120 calendar days of receipt, and 80 percent of such applications within 180 calendar days of receipt.

6.1.2 - Paper Applications – Accuracy

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 98 percent of paper CMS-855 initial applications in full accordance with all of the instructions in chapter 10 (with the exception of the timeliness standards identified in section *6*.1.1 above) and all other applicable CMS directives.

6.1.3 - Web-Based Applications - Timeliness

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 90 percent of CMS-855 Web-based initial applications within 45 calendar days of receipt, process 95 percent of CMS-855 Web-based initial applications within 60 calendar days of receipt, and process 99 percent of CMS-855 Web-based initial applications within 90 calendar days of receipt. This process generally includes, but is not limited to:

Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review;

- Verification of the application in accordance with sections 8.1 through 8.6 of this manual;

- Requesting and receiving clarifying information in accordance with section 8.3 of this manual;

- Supplier site visit (if necessary);

- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial.

6.1.4 - Web-Based Applications - Accuracy

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 98 percent of CMS-855 Web-based initial applications in full accordance with all of the instructions in chapter 15 (with the exception of the timeliness standards identified in section 6.1.3 above) and all other applicable CMS directives.

6.2 – Standards for Changes of Information

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

For purposes of timeliness, the term "changes of information" also includes:

1. CHOW, acquisition/merger, and consolidation applications submitted by the old owner;

2. CMS-588 changes submitted without a need for an accompanying complete CMS-855 application;

3. CMS-855R applications submitted independently (i.e., without being part of a CMS-855I or CMS-855B package); and

4. CMS-855 voluntary terminations

6.2.1 - Paper Applications - Timeliness

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 80 percent of paper CMS-855 changes of information within 60 calendar days of receipt, process 90 percent of paper CMS-855 changes of information within 90 calendar days of receipt, and process 95 percent of paper CMS-855 changes of information within 120 calendar days of receipt. This process generally includes, but is not limited to, the following activities:

- Receipt of the change request in the contractor's mailroom and forwarding it to the appropriate office for review;
- Prescreening the change request in accordance with section *7*.1 of this manual;
- Creating an L & T record and, if applicable, tying it to an enrollment record in PECOS;
- Verification of the change request in accordance with sections *8*.1 through *8*.6 of this manual, as well as the applicable instructions in sections *13*.1 and *13*.2 of this manual;
- Requesting and receiving clarifying information in accordance with section *8*.3 of this manual;
- Supplier site visit (if necessary);
- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial.

6.2.2 - Paper Applications - Accuracy

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 98 percent of paper CMS-855 changes of information in full accordance with all of the instructions in chapter 10 (with the exception of the timeliness standards identified in section *6*.2.1 above) and all other applicable CMS directives.

6.2.3 - Web-Based Applications - Timeliness

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 90 percent of CMS-855 Web-based changes of information applications within 45 calendar days of receipt, process 95 percent of CMS-855 Web-based changes of information within 60 calendar days of receipt, and process 99 percent of CMS-855 Web-based changes of information within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review;
- Verification of the change request in accordance with sections *8*.1 through *8*.6 of this manual, as well as the applicable instructions in sections *13*.1 and *13*.2 of this manual;
- Requesting and receiving clarifying information in accordance with section *8*.3 of this manual;

- Supplier site visit (if necessary);

- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary) for approval or denial.

6.2.4 - Web-Based Applications – Accuracy

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The contractor shall process 98 percent of CMS-855 Web-based change of information applications in full accordance with all of the instructions in chapter 1*5* (with the exception of the timeliness standards identified in section *6*.2.3 above) and all other applicable CMS directives.

6.3 - General Timeliness Principles

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

Unless stated otherwise, the principles discussed below apply to all applications discussed in sections *6*.9 through *6*.2.4 above (e.g., CHOW applications submitted by old and new owners, CMS-588 forms).

A. Clock Stoppages

The processing time clocks identified in sections *6*.1 and *6*.2 of this manual cannot be stopped or suspended for any reason. This includes, but is not limited to, the following situations:

- Referring an application to the OIG or the Payment Safeguard Contractor (PSC);

- Waiting for the final sales agreement (e.g., CHOW, acquisition/merger);

- Waiting for the RO to make a provider-based, HHA capitalization, or CHOW determination;

- Referring a provider to the Social Security Administration (SSA) to resolve a discrepancy involving a social security number (SSN), as explained in section 4.2.1 of this manual.

- Contacting CO (e.g., DPSE) or an RO's survey/certification staff with a question regarding the application in question or CMS policy.

Despite the prohibition on clock stoppages and suspensions, the contractor should always document any delays by identifying when the referral to CMS, the OIG, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. To illustrate, assume a contractor received an initial CMS-855B application on March 1. On March 30, the contractor sent an adverse legal

action question to CMS, and received a reply on April 7. The processing time clock did not stop from March 31 to April 7. However, the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

B. Calendar Days

Unless otherwise stated in this manual, all days in the processing time clock are "calendar" days, not "business days." If the 60th day (for initials) or 45th day (for changes of information) falls on a weekend or holiday, this is still the day by which the application must be processed. If the contractor is unable to finish processing the application until the next business day, however, it should document the file that the 60th day fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

C. Date-Stamping

As a general rule, all incoming correspondence must be date-stamped on the date it was received in the contractor's mailroom. This includes, but is not limited to:
Any CMS-855 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)

- Letters from providers. (The first page of the letter must be date-stamped.)

- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)

- Data furnished by the provider (via mail or fax) per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application; hence, it is necessary to determine the sequence in which the application and the additional pages were received.)

The timeliness clocks discussed in sections *6*.1 and *6*.2 above start on the date the application/envelope is date-stamped in the contractor's mailroom, not when the application is date-stamped or received by the provider enrollment unit. As such, the date-stamping activities described in the aforementioned bullets must be performed in the contractor's mailroom. In cases where the mailroom staff fails to date-stamp a particular document, the provider enrollment unit may date-stamp the page in question. However, there shall not be long lapses between the time it was received in the mailroom and the time the provider enrollment unit date-stamped the pages.

In addition, and unless stated otherwise in this manual or other CMS directive, all incoming enrollment applications (including change requests) must be submitted via mail.

D. When the Processing Cycle Ends

For: (1) fiscal intermediaries, and (2) carriers processing ASC or portable x-ray applications, the processing cycle ends on the date the contractor sends its recommendation for approval or denial to the State agency. In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the State or RO), the cycle ends on the date the contractor sends notification to the provider that the change has been processed. If notification to the provider is made via telephone, the cycle ends on the date the telephone call is made (e.g., the date the voice mail message is left).

For carriers processing applications other than those from ASCs and portable x-ray suppliers, the processing cycle ends on the date the carrier sends its approval/denial letter to the supplier. For change request approval/denial notifications made via telephone, the cycle ends on the date the telephone call is made (e.g., the date the voice mail message is left).

For any application that is rejected per section *7*.1 or *8*.3 of this manual, the processing time clock ends on the date the contractor sends notification to the provider that the application has been rejected.

E. PECOS

Unless stated otherwise in this manual, the contractor must create an L & T record in PECOS no later than 15 calendar days after its receipt of the provider's application in the contractor's mailroom. Moreover, the contractor must establish a complete enrollment record in PECOS – if applicable - prior to its approval or denial of (or recommendation of approval or denial of) the provider's application; to the maximum extent possible, the contractor shall establish the enrollment record at one time, rather than on a piecemeal basis.

The L & T and enrollment record requirements in the previous paragraph apply to all applications identified in sections *6*.1 and *6*.2 above (e.g., reassignments, CHOW applications submitted by old and new owners).

In situations where the contractor cannot create an L & T record within 15 days due to missing information (e.g., no NPI was furnished), the contractor shall document the provider file accordingly.

18 – Initial Enrollment Determination

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

20 – *On-site Inspections and* Site Verifications

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

All providers and suppliers are subject to unannounced site visits prior to receiving Medicare billing privileges or subsequent to receiving Medicare billing privileges. Unannounced site visits are designed to confirm that a physician, non-physician practitioner or other provider or supplier is operating at the practice location furnished to Medicare as part of the enrollment process and that the physician, non-physician practitioner or other provider or supplier is in compliance with applicable regulation provisions for their provider or supplier types.

Carriers, fiscal intermediaries and A/B MACs shall not conduct site verifications to determine if a provider or supplier, including physician and non-physician practitioners, is operational unless CMS has already issued formal guidance or unless CMS issues instructions directing the Medicare contractor to conduct a pre-enrollment site verification or post-enrollment site verification.

The IDTFs shall be excluded from these instructions.

2*0*.1 - Site Verifications to Determine Operational Status

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

When conducting a site verification to determine whether a practice location is operational, the Medicare contractor shall make every effort to limit its site verification to an external review of the practice location to determine if it is operational. If the Medicare contractor cannot determine if the practice location is operational based on an external review of the practice location, the Medicare contractor shall conduct an unobtrusive site verification by limiting its encounter with provider or supplier personnel or medical patients.

When conducting site verifications to determine whether a practice location is operational, the Medicare contractor shall:

- Document the date and time of the attempted visit to include the name of the individual attempting the visit;
- As appropriate, photograph the provider or supplier's business for inclusion in the supplier's file on an as needed basis. All photographs should be date/time stamped;
- Fully document observations made at the facility which could include facts such as; the facility was vacant and free of all furniture, a notice of eviction or similar documentation is posted at the facility, the space is now occupied by another company;
- Write a report of their findings regarding each site verification; and
- Include a signed declaration stating the facts and verifying the completion of the site verification. (A sample declaration is below and may be revised as necessary)

Declaration of (Name of Inspector/Investigator)

In the Case of _______________
Provider/Supplier No.___________

I, **(Name of Inspector/Investigator)**, declare as follows:

1. I have personal knowledge of each of the following matters in this Declaration except to those facts alleged on information and belief, and as to those matters, I believe them to be true. I am competent to testify to the following:

2. I am an Investigator for [Insert Contractor Name]. [Insert Contractor Name] is a CMS-contracted [Intermediary/Carrier/A/B Medicare Administrative Contractor (MAC)].

3. I have been trained as an Investigator and Site Inspector by [Insert Contractor Name], and I am knowledgeable of Medicare's compliance statutes, regulations and standards for suppliers enrolled in the Medicare program. I have worked in this capacity for [Insert years] years. During this period, I have conducted over [Insert Number] site inspections of the offices and facilities of providers/suppliers; and since January [Year in which case occurs], I have conducted over [Insert Number] site inspections related to the compliance of suppliers with Medicare's requirements.

4. I prepared the attached document entitled "[Title of Document]," which is the report of my attempts to inspect Petitioner's facility. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report.

5. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this _**(Date)**__ day of _**(Month) (Year)**_ in _**(City)**_, _**(State)**_.

____

SIGNATURE OF DECLARANT

Site verifications should be done Monday through Friday (excluding holidays) during their posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m. If during the first attempt, there are obvious signs that facility is no longer operational no second attempt is required. If, on the first attempt the facility is closed but there are no obvious indications the facility is non-operational, a second attempt on a different day during posted hours of operation should be made.

If a physician, non-physician practitioner, or other provider or supplier is determined not to be operational, the Medicare contractor shall revoke the Medicare billing privileges of the provider or supplier, unless the provider or supplier has submitted a change which notified the Medicare contractor of a change in practice location. Within 7 calendar days of CMS or the Medicare contractor determining that the provider or supplier is not operational, the Medicare contractor shall update PECOS or the applicable claims processing system (if the provider does not have an enrollment record in PECOS) to revoke billing Medicare billing privileges and issue a revocation notice to the provider or supplier. The Medicare contractor shall use either 42 CFR §424.535(a)(5)(i) or 42 CFR §424.535(a)(5)(ii) as the legal basis for revocation. Consistent with 42 CFR §424.535(g), the date of revocation is the date that CMS or the Medicare contractor determines that the provider or supplier is no longer operational. The Medicare contractor shall establish a 2-year enrollment bar for suppliers that are not operational. The Medicare contractor shall afford the provider or supplier with the applicable appeal rights in the revocation notification letter.

2*0*.2 - Site Verifications to Determine if a Provider or Supplier Meets or Continues to Meet the Regulatory Requirements for Their Provider or Supplier Type

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

When conducting a site verification to determine whether a provider or supplier continues to meet the regulatory provisions for the provider or supplier type, the Medicare contractor shall conduct its site verification in a manner which limits the disruption for the provider or supplier.

When conducting site verifications to determine whether a provider or supplier continues to meet the regulatory provisions for the provider or supplier type, the Medicare contractor shall:

- Document the date and time of the attempted visit to include the name of the individual attempting the visit;

- As appropriate, photograph the provider or supplier's business for inclusion in the supplier's file on an as needed basis. All photographs should be date/time stamped;

- Fully document observations made at the facility which could include facts such as; the facility was vacant and free of all furniture, a notice of eviction or similar documentation is posted at the facility, the space is now occupied by another company; and

- Write a report of their findings regarding each onsite inspection; and

- A signed declaration stating the facts and verifying the completion of the site verification. (Refer to section 22.1 for a sample declaration.)

Site verifications should be done Monday through Friday (excluding holidays) during their posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m. If during the first attempt, there are obvious signs that facility is no longer operational no second attempt is required. If, on the first attempt the facility is closed but there are no obvious indications the facility is non-operational, a second attempt on a different day during posted hours of operation should be made.

If a Medicare contractor determines that the provider or supplier does not comply with the regulatory provisions for their provider or supplier type, the Medicare contractor shall revoke the provider or supplier's Medicare billing privileges. Within 7 calendar days of CMS or the Medicare contractor determining that the provider or supplier does not comply with the regulatory provisions for their provider or supplier type, the Medicare contractor shall update PECOS or the applicable claims processing system (if the provider does not have an enrollment record in PECOS) to revoke billing Medicare billing privileges and issue a revocation notice to the provider or supplier. The Medicare contractor shall use 42 CFR §424.535(a)(1) as the legal basis for revocation. Consistent with 42 CFR §424.535(g), the date of revocation is the date that CMS or the Medicare contractor determines that the provider or supplier is no longer in compliance with regulatory provisions for their provider or supplier type. The Medicare contractor shall establish a 2-year enrollment bar for the providers and suppliers that are not in compliance with provisions for their enrolled provider or supplier type. The Medicare contractor shall afford the provider or supplier with the applicable appeal rights in the revocation notification letter.

2*0*.3 - National Supplier Clearinghouse (NSC)

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

The (NSC) shall continue to conduct onsite inspections consistent with their Statement of Work and any instructions issued by the NSC project officer.

24.21 – Model Approval Letter for Providers Who Order and Refer Only

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

CMS alpha representation
Contractor

[Month Day & Year]

[Provider/Supplier Name]
[Address]
[City, State & Zip Code]
Dear [Insert Provider/Suppler name]:

We are pleased to inform you that you are in the Medicare program for the sole purpose of ordering and referring items or services for Medicare beneficiaries to other providers and suppliers. Listed below is the information reflected in your Medicare record.

Medicare Enrollment Information

Provider\supplier name:	[Insert name]
Practice location:	[Insert address]
National Provider Identifier (NPI):	[Insert NPI]
Specialty:	[Insert provider/supplier specialty]

Please verify the accuracy of your information. If you disagree with any portion of this initial determination or have any questions, please call your Medicare Fee-For-Service contractor at [insert phone number] between the hours of [insert office hours].

Additional information about the Medicare program, including billing, fee schedules, and Medicare polices and regulations can be found at our Web site at [insert Web site address] or the Centers for Medicare & Medicaid Services' (CMS) Web site at www.cms.hhs.gov/home/medicare.asp.

Sincerely,

[Your Name]
[Title]

27 – Deactivations and Revocations

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

If circumstances warrant, a fee-for-service contractor shall deactivate or revoke a provider or supplier's Medicare billing privileges under certain circumstances. Deactivation or revocation of Medicare billing privileges will not impact a provider or supplier's ability to submit claims to non-Medicare payers using their National Provider Identifier.

27.1 – CMS or Contractor Issued Deactivations

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

A. General Instructions

The contractor may deactivate a provider or supplier's Medicare billing privileges when:

- A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;

- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or

- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation.

Providers and suppliers that fail to promptly notify the contractor of a change (as described above) must submit a complete Medicare enrollment application to reactivate their Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement.

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated DPSE contractor liaison no later than the last calendar day of each month.

B. Special Reactivation Instructions for Part B Suppliers

(This section does not apply to: (1) providers and suppliers that complete the CMS-855A application, and (2) DMEPOS suppliers.)

To ensure that a supplier that has reactivated its Medicare billing privileges does not become subject to a second deactivation for non-billing within 30 days of the reactivation, the contractor shall:

1. End-date the existing PTAN-NPI combination in sections 1 and 4 of PECOS with the non-billing end-date in MCS, and

2. Issue a new Provider Transaction Access Number (PTAN) to the provider or supplier, and associate the new PTAN with the NPI in sections 1 and 4 of PECOS.

For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals, the contractor shall establish the reactivation effective date as the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location.

The exception to this is if the supplier has at least one other enrolled practice location (under the same TIN) for which it is actively billing Medicare; here, the contractor shall establish and enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later. To illustrate, if the supplier has only one enrolled practice location and that site is deactivated for non-billing, the effective date is the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location. On the other hand, suppose the supplier has two enrolled locations – X and Y - under its TIN. Location X is actively billing Medicare, but Y is deactivated for non-billing. The reactivation effective date for Y would be the later of: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS. This is because the supplier has at least one other location – Location X – that is actively billing Medicare.

For individual and organizational suppliers other than those identified in the beginning of the previous paragraph, the contractor shall enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later.

If the supplier's PTAN is only established in MCS, no action is required if the end-dated non-billing number is not in PECOS.

C. DMEPOS Deactivation

The NSC shall require a DMEPOS supplier whose billing privileges are deactivated for non-submission of claims (see CFR 42 CFR 424.540) to submit a new Medicare enrollment application and meet all applicable enrollment criteria, including a site visit, and accreditation when applicable, before an applicant can be approved. The NSC may not establish a retrospective billing date for a DMEPOS supplier whose billing privileges were deactivated due to claims inactivity.

D. Deactivation and Appeals Rights

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is made.

27.2 – Contractor Issued Revocations

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

A. Revocation Reasons

The contractor may issue a revocation using revocation reasons 1 through 11 below without prior approval from CMS. Sections *27*.3 through *27*.3.2 below address revocation reason 12 (42 CFR §424.535(a)(8)), which requires DPSE review and approval.

When issuing a revocation, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter as the basis for revocation.

Revocations based on non-compliance:

Revocation 1 (42 CFR §424.535(a)(1))

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR Part 488.

Noncompliance includes, but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider or supplier has failed to pay any user fees as assessed under 42 CFR Part 488.

Revocation 2

The provider or supplier has lost its license(s) or is not authorized by the Federal/state/local government to perform the services for which it intends to render. (In its revocation letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this chapter. Note that the contractor must identify in the revocation letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with.)

Revocation 3

The provider or supplier no longer meets CMS regulatory requirements for the specialty for which it has been enrolled. (In its revocation letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this chapter. Note that the contractor must identify in the revocation letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with.)

Revocation 4 (42 CFR §424.535(a)(1))

The provider or supplier (upon discovery) does not have a valid SSN/employer identification number for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.

Revocations based on provider or supplier conduct:

Revocation 5 (42 CFR §424.535(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

If an excluded party is found, notify DPSE immediately. DPSE will notify the Government Task Leader (GTL) for the appropriate PSC. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

Revocations based on felony:

Revocation 6 (42 CFR §424.535(a)(2))

The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.

(i) Offenses include—

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

The Centers for Medicare & Medicaid Services (CMS) stresses, however, that an enrollment bar issued pursuant to 42 CFR §424.535(c) does not preclude CMS or its contractors from denying re-enrollment to a provider or supplier who was convicted of a felony within the preceding 10-year period or who otherwise does not meet all criteria necessary to enroll in Medicare.

Revocations based on false or misleading information:

Revocation 7 (42 CFR §424.535(a)(4))

The provider or supplier certified as ‘‘true’’ misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)

Revocations based on misuse of billing number

Revocation 8 (42 CFR §424.535(a)(7))

The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in 42 CFR §424.80 or a change of ownership as outlined in 42 CFR § 489.18.

Additional revocation reasons:

Revocation 9 (42 CFR §424.535(a)(5))

The CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Revocation 10 (42 CFR §424.535(a)(6))

The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 30 calendar days of the provider or supplier's notification from CMS to submit an enrollment application and supporting documentation.

Revocation 11 (42 CFR §424.535(a)(9))

The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.

Note the following with respect to Revocation 11:

- This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

- If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not revoke the supplier's billing privileges on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR 424.535(a)(5)(ii) or via another verification process - that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may revoke the supplier's billing privileges.

B. Effective Date of Revocations

Per 42 CFR §405.874(b)(2), a revocation is effective 30 days after CMS or the CMS contractor (including the NSC) mails the notice of its determination to the provider or supplier. However, per 42 CFR §424.535(g) a revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction as described in 42 CFR §424.535(a)(3), (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.
Note that in accordance with CFR §424.565, if an individual or organization identified in section 7.1(A) of this chapter fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009. Moreover, no later than 10 calendar days after the contractor assesses the overpayment, the contractor shall notify its DPSE liaison of the amount assessed.

As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its recommendation letter. It is up to the provider/supplier to furnish this data on its own volition.

- Has the ultimate discretion to determine whether sufficient "proof" exists.

C. Payment

Per 42 CFR §405.874(b)(3), Medicare does not pay and a CMS contractor rejects claims for items or services submitted with a service date on or after the effective date of a provider's or supplier's revocation.

D. Reapplying After Revocation

As stated in 42 CFR §424.535(c), after a provider, supplier, delegated official, or authorizing official that has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar.

Unless stated otherwise in this section, the re-enrollment bar is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation. The contractor shall establish the re-enrollment bar in accordance with the following:

1 year *(AR 73)* – License revocation/suspension that a deactivated provider (i.e., is enrolled, but is not actively billing) failed to timely report to CMS; provider failed to respond to revalidation request.

2 years *(AR 74)* – The provider is no longer operational.

3 years *(AR 81)* – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information.

For all other revocation reasons, the contractor shall contact its DPSE liaison; DPSE will establish the appropriate enrollment bar for that particular case.

The contractor shall update PECOS to reflect that the individual is prohibited from participating in Medicare for the 1, 2, or 3-year period reflected by the enrollment bar in question.

Note also that reenrollment bars apply only to revocations. The contractor shall not impose a reenrollment bar following a denial of an application.

E. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(g), any physician, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

F. Reporting of Final Adverse Action - Compliance

If a physician or non-physician practitioner reports the imposition of a final adverse action (other than felony convictions) against him or her within the reporting timeframes specified in 42 CFR §424.516, and if the final adverse action is one for which the provider's billing privileges would typically be revoked, the contractor shall:

- Treat the submission as a voluntary withdrawal, rather than a revocation; and

- Establish an overpayment back to the date of the reportable event if the practitioner furnished services after the reportable event.

By reporting final adverse actions in a timely manner (i.e., 30 days), physicians and non-physician practitioners can avoid the imposition of an enrollment bar.

(As alluded to above, this policy does not apply to felony convictions. The contractor must revoke the provider's billing privileges in such cases even if the provider timely reported the conviction.)

(For purposes of this section, the term non-physician practitioner only includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; and registered dietitians or nutrition professionals.)

G. Notification to Other Contractors

If the contractor revokes a provider or supplier's Medicare billing privileges, the contractor shall determine, via a search of PECOS, whether the provider/supplier is enrolled with any other Medicare contractors. If the contractor determines that the revoked provider/supplier is indeed enrolled with another contractor(s), the revoking contractor shall notify these other contractors of the revocation; the notification shall be done via e-mail and shall contain a short description of the reason for the revocation.

Upon receipt of this notification from the revoking contractor, the receiving contractor shall determine whether the provider or supplier's billing privileges should be revoked in its jurisdiction as well. Should the contractor need assistance in making this determination, it may contact its DPSE liaison or BFL.

H. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 19 of this chapter.

I. Summary

If the contractor determines that a provider's billing privileges should be revoked, it shall undertake the activities described in this section, which include, but are not limited to:

- Revoking the provider's billing privileges back to the appropriate date;
- Establishment of the applicable reenrollment bar;
- Updating PECOS to show the length of the reenrollment bar;
- Assessment of an overpayment, as applicable;

- Providing DPSE with the amount of the assessed overpayment within 10 days of the overpayment assessment; and

- Affording appeal rights.

27.2.1 - Revocations Involving Certified Suppliers and Providers

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

If the contractor determines that one or more of the revocation reasons identified in section ***27***.2 of this manual are applicable, the contractor may revoke the billing privileges of a certified provider or certified supplier without making a recommendation for approval or denial to the State and RO. It can, in other words, revoke billing privileges at the contractor level. However, as indicated in section ***27***.2, the contractor shall first notify DPSE prior to initiating any revocation action.

In revoking the provider or supplier, the contractor shall:

- Issue the revocation letter in accordance with section ***27***.2; the contractor shall copy the RO and/or the State on said letter;

- After determining the effective date of the revocation, end-date the entity's enrollment record in PECOS in the same manner as it would upon receipt of a tie-out notice from the RO.

- Afford the appropriate appeal rights per section 19 of this manual.

***27*.3 - DPSE Issued Revocations**

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

Based on information from a Program Safeguard Contractor (PSC), CMS satellite office, or other CMS component, including a regional office, DPSE may request that fee-for-service contractors revoke a provider or supplier's Medicare billing privileges using revocation 12. Fee-for-service contractors shall only issue a revocation using Revocation 12 when they receive a properly executed Joint Signature Memorandum from CMS.

27.3.1 - PSC Identified Revocations

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

If a PSC believes that the use of revocation 12 is appropriate, the PSC will develop a case file, including their reason(s) for revocation, and submit the case file and all supporting documentation to their respective government task leader (GTL). The PSC will provide the GTL with the name, all known billing numbers, including the NPI and associated Medicare billing numbers, and locations of the provider or supplier in question as well as detailed information to substantiate the revocation action.

The GTL will review the PSC case file and:

- Return the case file to PSC for additional development, or
- Recommend that DPSE consider approval the PSC recommendation for revocation.

If DPSE concurs with GTL's revocation recommendation, DPSE will instruct the applicable fee-for-service contractor to revoke a billing number through a Joint Signature Memorandum and notify the DBIMO of the action taken.

27.3.2 - CMS Satellite Office or Regional Office Identified Revocations

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

If a CMS satellite office or regional office believes that the use of revocation 12 (see 42 is appropriate, the CMS satellite office or regional office will develop a case file, including the reason(s) for revocation, and submit the case file and all supporting documentation to DPSE. The CMS satellite office or regional office will provide the DPSE with the name, all known billing numbers, including the NPI and associated Medicare billing numbers, and locations of the provider or supplier in question as well as detailed information to substantiate the revocation action.

If DPSE concurs with revocation recommendation, DPSE will instruct the applicable contractor to revoke the billing number and notify DBIMO of the action taken.

Revocation 12 (42 CFR §424.535(a)(8))

The provider, supplier or DMEPOS supplier submits a claim or claims for services or supplies that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

27.4 - External Reporting Requirements

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

No later than the last day of January, April, July and October of each year, the contractor shall furnish to its DPSE liaison via e-mail the following information for the previous quarter:

A. Fiscal Intermediaries (includes A/B MACs)

- Number of recommendations for denial of initial CMS-855A applications (including new owner CHOWs) and the three most frequent reasons for said recommendations;

- Number of revocations (or recommendations for revocations) and the three most frequent reasons for said actions.

B. Carriers (includes A/B MACs)

- Number of denials of initial CMS-855 applications (this includes denial recommendations for ASCs and PXRS) and the three most frequent reasons for said denials. (CMS-855B and CMS-855I denials shall be listed separately.)

- Number of revocations and the three most frequent reasons therefore. (CMS-855B and CMS-855I revocations shall be listed separately.)

The contractor need not submit this data to CMS via any sort of spreadsheet. A simple e-mail is sufficient. The first report is due by January 31, 2008, and shall cover actions taken in October, November and December of 2007.

*2*9 - *Provider and Supplier Revalidations and DMEPOS Re-enrollment*

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

Per 42 CFR § 424.515, Medicare providers and suppliers (other than DMEPOS suppliers) must resubmit and recertify the accuracy of their enrollment information every five years in order to maintain Medicare billing privileges. Contractors may initiate revalidation activities at any time during the fiscal year.

The following principles apply to revalidation:

- The processing times for "initial" applications – outlined in section ***6***.1 of this manual – apply to revalidation applications.

- Per 42 CFR § 424.515, a provider whom the contractor requested to furnish all requested information (as part of the revalidation) must do so within 60 calendar days after the date the contractor notified the provider of the need to revalidate. If the provider fails to do so, the contractor shall revoke the provider's billing privileges using existing revocation procedures.

- The provider must submit all required documentation with its application, even if such documentation is already on file with the contractor.

The contractor shall verify all data furnished on the application – just as it would with an initial enrollment – using the procedures identified in this manual (e.g., section ***8***.2)

*2*9.1 - Supplementary Revalidation Activities

(Rev.354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

If, as of the last day of the eighth month of the fiscal year for legacy contractors (May 31) or the current contract year for A/B MAC contractors, the contractor's provider enrollment workload and costs are both less than what was projected to CMS at the beginning of the fiscal/contract year, the contractor shall undertake revalidation efforts commensurate with the amount of surplus funding. In doing so, the contractor shall

first revalidate those providers that do not have an established enrollment record in PECOS.

Revalidation of the remaining providers shall be conducted in roughly the following order:

1. Providers that have not updated their enrollment information within the previous 5 years (i.e., have not submitted a CMS-855 change of information within that time span).

2. High-risk providers (e.g., provider is located in a historically high-risk metropolitan area or is of a high-risk provider/supplier type).

3. Providers that are not receiving payments via EFT.

4. High-reimbursement providers.