CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 314	Date: November 27, 2009
	Change Request 6734

SUBJECT: Clarification of Deactivation Instructions

I. SUMMARY OF CHANGES: This change request removes language that is inconsistent with recently-enacted changes regarding the effective date of reactivations, and reminds contractors not to issue appeal rights to providers and suppliers when deactivating their Medicare billing privileges, as there is no legal basis for granting such rights.

NEW / REVISED MATERIAL
EFFECTIVE DATE: December 28, 2009
IMPLEMENTATION DATE: December 28, 2009

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
R	10/6.1.4/Effective Billing Date for Physicians, Non-Physician Practitioners, and Physician or Non-Physician Practitioner Organizations
R	10/13.1/CMS or Contractor Issued Deactivations

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
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):
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: 314	Date: November 27, 2009	Change Request: 6734

SUBJECT: Clarification of Deactivation Instructions

Effective Date: December 28, 2009

Implementation Date: December 28, 2009

I. GENERAL INFORMATION

A. Background: This change request removes language that is inconsistent with recently-enacted changes regarding the effective date of reactivations and reminds contractors not to issue appeal rights to providers and suppliers when deactivating their Medicare billing privileges, as there is no legal basis for granting such rights.

B. Policy: The purpose of this change request is make the clarifications described above.

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	
6734.1	The contractor shall note that Pub. 100-08, section 6.1.4, chapter 10, is being revised to remove language that is inconsistent with recently-enacted changes to Pub. 100-08, section 13.1, chapter 10, regarding the effective date of reactivations.	X			X						
6734.2	The contractor shall note that it should not issue appeal rights to providers and suppliers when deactivating their Medicare billing privileges, as there is no legal basis for granting such rights.	X		X	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: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact: Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov.
Post-Implementation Contact: Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov.

VI. FUNDING

Section A: 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.

Section B: *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.

6.1.4 – Effective Billing Date for Physicians, Non-Physician Practitioners, and Physician or Non-Physician Practitioner Organizations

(Rev.314, Issued: 11-27-09, Effective: 12-28-09, Implementation: 12-28-09)

(This section 6.1.4, only applies to the following individuals and organizations: 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 physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.)

In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location. Note that the date of filing for Internet-based PECOS applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement.

In accordance with 42 CFR §424.521(a), the individuals and organizations identified above may, however, retrospectively bill for services when:

- The supplier has met all program requirements, including State licensure requirements, and

- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The effective date of billing for a physician/non-physician practitioner and physician/non-physician practitioner's organization is the later of the date of filing or the date the physician or non-physician practitioner began furnishing services at the practice location.

EXAMPLE 1: Dr. Joe is establishing a new practice location on July 1, 2009, and submits his enrollment application on June 10, 2009. The effective date is July 1, 2009. Obviously, there is no period of retrospective payment, since Dr. Joe submitted his CMS-855 application prior to the start date.

EXAMPLE 2: Dr. Joe started working at his new practice location on August 15, 2009 and filed his enrollment application on September 1, 2009. While September 1, 2009, is the later of these two dates and is therefore the effective date of filing, the effective date for billing purposes (and for retrospective payment) is August 15, 2009.

EXAMPLE *3*: Dr. Joe started working on January 2, 2009 and submits his enrollment application on March 1, 2009. Dr. Joe's effective date of filing is March 1, 2009, but his effective date for billing purposes is limited to the 30 days prior to March 1, 2009. In this case, Dr. Joe's effective billing date is January 3*0*, 2009.

NOTE: This calculation includes 28 days for *February.*

*I*n each scenario described above, the contractor shall enter the effective date of billing into sections 1 and 4 of PECOS.

For information on reactivation effective dates, see section 13.1, of this chapter.

13.1 – CMS or Contractor Issued Deactivations

(Rev.314, Issued: 11-27-09, Effective: 12-28-09, Implementation: 12-28-09)

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.