



NATIONAL PROVIDER  
ENROLLMENT CONFERENCE

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# Maintaining Compliance with Enrollment Requirements and the Appeals Process

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# Session Overview

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- ❑ **Deactivation Authority**
- ❑ **Revocation Authority**
- ❑ **Appeals**
- ❑ **Examples**
- ❑ **Q & A**

# Two Administrative Actions: Very Different Consequences

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- ❑ **Deactivation:** “Pause button”
  - ❑ Provider or supplier must complete and submit a new enrollment application to reactivate Medicare billing privileges
  - ❑ Or, when deemed appropriate, recertify that the enrollment information on file is correct
  - ❑ *See* 42 C.F.R. § 424.540(a)
- ❑ **Revocation:** Removal of billing privileges and termination of provider/supplier agreement
  - ❑ Re-enrollment bar for 1 to 3 years
  - ❑ *See* 42 C.F.R. § 424.535(a)

# Deactivation Authorities

# Deactivations and Reactivations

## CMS can **deactivate** Medicare billing privileges for:

- ✗ Non-billing for 12 months
- ✗ **Failure to respond to revalidation**
- ✗ **Failure to report a change with 90 days (practice location, managing employee)\***
- ✗ Failure to report a change in ownership in 30 days

## To **reactivate** Medicare billing privileges:

- ✓ **Must submit a complete CMS-855 application**
- ✓ **Effective date based on receipt date of the reactivation application**
- ✓ Does not require a new state survey for certified providers (exception for HHAs)



Billing privileges were paused, but can be restored upon the submission of a new enrollment application or updated information

*\* Reporting a change of information to the state, Regional Office, or another agency does not meet Medicare's reporting requirements and may lead to deactivation/revocation.*

# Revocation Authorities

# 14 Reasons for Revocation

42 C.F.R. §424.535(a)

Noncompliance



1

Provider or Supplier Conduct



2

Felonies



3

False or Misleading Information



4

On-Site Review



5

Grounds Related to Provider & Supplier Screening Requirements



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Misuse of Billing Number



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Abuse of Billing



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Failure to Report



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Failure to Document or Provide CMS Access to Documentation



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Initial Operating Funds for HHAs



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# Re-Enrollment Bar

42 CFR §424.535(c)

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- ❑ If a provider or supplier has its/hers/his billing privileges revoked, it/she/he is barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar.
- ❑ Re-enrollment bar lasts **1 – 3 years**.



# Revocation Effective Dates

42 CFR §424.535(g)

## Retroactive

### **424.535(a)(1) Licensure**

The date of the license suspension or revocation

### **424.535(a)(2) Exclusion**

The date of the exclusion

### **424.535(a)(3) Felonies**

The date of the felony conviction

### **424.535(a)(5) On-site Review**

The date CMS or its contractor determined the provider  
or supplier was non-operational

## Prospective

### **All Other Authorities**

Thirty days from the date of the contractor's  
mailing of the revocation letter

# Noncompliance

## 42 CFR §424.535(a)(1)

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- ❑ The provider or supplier has violated an enrollment requirement listed on the application it/he/she uses for enrollment purposes (e.g., 855I, 855B, or 855A).
- ❑ Licensure violations are most common use of this authority.
- ❑ All violations of DME supplier standards fall under this authority. *See* 42 C.F.R. § 424.57(c).
- ❑ All violations of IDTF supplier standards fall under this authority. *See* 42 C.F.R. § 410.33(g).

# Noncompliance

## 42 CFR §424.535(a)(1)

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- ❑ **DME Suppliers:** any changes of information supplied on an application must be reported within 30 days.  
*See 42 C.F.R. § 424.57(c)(2).*
- ❑ **IDTF:** Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.  
*See 42 C.F.R. § 410.33(g)(2).*
- ❑ **All entities other than physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations:** 30 days for a change of ownership (including authorized officials (AO) and designated officials (DO)) and 90 days for all other changes. *See 42 C.F.R. § 424.516(e).*

# Provider or Supplier Conduct

42 CFR §424.535(a)(2)

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- ❑ The provider, 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 excluded from the Medicare, Medicaid and any other Federal Health Care Program.

# Felonies

## 42 CFR §424.535(a)(3)

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- ❑ The provider, supplier, or **any owner or managing employee** of the provider or supplier was, within the preceding **10 years**, convicted of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries.
- ❑ Corresponding Denial authority at 42 CFR §424.530 (a)(3)
  - ❑ If conviction within 10 years is disclosed/discovered during initial enrollment application processing or on subsequent application submissions the application in question will be denied and a revocation or denial will be effectuated.

# Felonies

42 CFR §424.535(a)(3)

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## Offenses include:

- ❑ Felony crimes against persons, such as **murder, rape, and assault**
- ❑ Financial crimes, such as **extortion, embezzlement, income tax evasion, insurance fraud** and other similar crimes
- ❑ 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
- ❑ Any felonies that would result in mandatory exclusion under section 1128(a) of the Act

# Felonies

42 CFR §424.535(a)(3)

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## **CMS may revoke regardless of whether:**

- ❑ There is a post-trial motion or appeal pending
- ❑ The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed
- ❑ An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld
- ❑ An individual participated in a plea agreement

# Poll Question One





Questions?

# False or Misleading Information

42 CFR §424.535(a)(4)

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- ❑ 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
- ❑ Omission of information constitutes non-reporting
- ❑ Partial reporting or mischaracterization may constitute non-reporting
- ❑ Must report Adverse Legal Actions (ALA) in all sections of applications that require the ALA reporting

# Final Adverse Legal Actions

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## The updated list of reportable Final Adverse Actions is as follows:

- ❑ Felony and Misdemeanor conviction(s) within 10 years
- ❑ Current or Past Suspension(s)/Revocation(s) of a medical license
- ❑ Current or Past Suspension(s) Revocation(s) of an accreditation
- ❑ Current or Past Suspension(s) or Exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)
- ❑ Current or Past Debarment(s) from participation in any Federal Executive Branch procurement or non-procurement program
- ❑ Medicaid exclusion(s), revocation(s) or termination(s) of any billing number
- ❑ Any other Current or Past Federal Sanction(s)

*Please note: Medicare Payment Suspensions and CMS-Imposed Medicare Revocations are **NO LONGER** required to be reported.*

# On-site Review

42 CFR §424.535(a)(5)

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**Upon on-site review or other reliable evidence, CMS determines that the provider or supplier is:**

- No longer operational to furnish Medicare-covered items or services.

# Operational

## 42 CFR §424.502

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- ❑ Must have a qualified physical practice location
- ❑ Must be open to the public for the purpose of providing health care related services
- ❑ Must be prepared to submit valid Medicare claims
- ❑ Must be properly staffed to furnish items or services
- ❑ Must possess the necessary equipment to furnish items and services

# Misuse of Billing Number

## 42 CFR §424.535(a)(7)

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- ❑ The provider or supplier knowingly sells to or allows another individual or entity to use its billing number.
- ❑ Valid reassignments are permissible and do not fall under this revocation authority.
- ❑ Valid changes in ownership do not fall under this revocation authority.

# Abuse of Billing Privileges

42 CFR §424.535(a)(8)(i)

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## Abuse of billing privileges includes the following:

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

# Abuse of Billing Privileges

## 42 CFR §424.535(a)(8)(ii)

- ❑ CMS determines that the provider or supplier has a **pattern or practice** of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
  - ❑ The percentage of submitted claims that were denied.
  - ❑ The reason(s) for the claim denials.
  - ❑ Whether the provider or supplier has any history of final adverse actions and the nature of any such actions.
  - ❑ The length of time over which the pattern has continued.
  - ❑ How long the provider or supplier has been enrolled in Medicare.
  - ❑ **Any other information** regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.



# Poll Question Two



Questions?

# Failure to Report

## 42 CFR §424.535(a)(9)

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- ❑ Applicable to physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.
- ❑ Revocation is possible when any of the above fails to report any adverse legal action or a change in practice location within 30 days.

# Failure to Document or Provide CMS Access to Documentation

## 42 CFR §424.535(a)(10)

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### ❑ Who?

- ❑ A provider or a supplier that **furnishes** covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services OR
- ❑ A physician who orders/certifies home health services and the physician/other eligible professional who **orders** items of DMEPOS or clinical laboratory or imaging services

### ❑ Length of Time?

- ❑ 7 years from date of service

# Failure to Document or Provide CMS Access to Documentation

## 42 CFR §424.535(a)(10)

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- ❑ **Manner?**

- ❑ Written request sent to correspondence address OR hand delivered request to correspondence address/practice location

- ❑ **When?**

- ❑ Request will specify the amount of days which are allotted for the production of documents to be considered timely

# Medicaid Termination

42 CFR §424.535(a)(12)

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- ❑ Action taken when Medicaid billing privileges are terminated or revoked by a State Medicaid Agency.
- ❑ “For Cause” terminations are reported to CMS by states
- ❑ Each state determines what it considers “for cause”
- ❑ Common underlying reasons terminations are deemed “for cause” include adverse licensure actions, federal exclusions, fraudulent conduct, and abusive billing.

# Prescribing Authority

42 CFR §424.535(a)(13)

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- ❑ Action can be taken when a physician or eligible professional's **Drug Enforcement Administration (DEA) Certificate of Registration** is suspended or revoked; or
- ❑ The applicable licensing or administrative body for any state in which the physician or eligible professional practices **suspends or revokes** the physician or eligible professional's ability to prescribe drugs.

# Improper Prescribing Practices

42 CFR §424.535(a)(14)

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- ❑ CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:
  - ❑ The pattern or practice is **abusive** or **represents a threat to the health and safety of Medicare beneficiaries** or both.
  - ❑ The pattern or practice of prescribing fails to meet **Medicare requirements**.



# Poll Question Three



Questions?



# Appeals

# Appeal Rights

42 C.F.R. § 405.803

- ❑ For purposes of provider enrollment, **appeal rights extend from initial determinations**, which include, but are not limited to:
  - ❑ The **denial** of enrollment in the Medicare program;
  - ❑ The **revocation** of Medicare billing privileges and the termination of any corresponding provider agreement or supplier agreement;
  - ❑ The **effective date** of the approval of enrollment and any corresponding provider agreement or supplier agreement;
  - ❑ The inclusion of a provider/supplier on the **CMS Preclusion List**.
- ❑ Providers and suppliers are advised of their appeal rights in the initial determination letter, which also contains notification of the denial, revocation, effective date, or preclusion list determination.
- ❑ **Regulatory Authority:** Pursuant to 42 CFR §405.803, a provider or supplier may appeal an initial determination made by CMS or its contractor by following the procedures specified in part 498.

# Types of Appeal

42 C.F.R. § 405.803/498.22

## ❑ Corrective Action Plan (CAP)

- ❑ A CAP allows a provider or supplier an opportunity to demonstrate compliance by correcting the deficiencies (if possible) that led to denial of enrollment or revocation of billing privileges.
- ❑ A CAP may only be submitted in response to the denial of an enrollment application under 42 CFR §424.530 or in response to a revocation for noncompliance under 42 CFR §424.535(a)(1).
- ❑ When submitting a CAP, a provider or supplier has only one opportunity to correct all of the deficiencies that served as the basis of the initial determination.

## ❑ Reconsideration

- ❑ A reconsideration request allows the provider or supplier to demonstrate if there was an error in the initial determination at the time the initial determination was made.

# Corrective Action Plans

42 C.F.R. § 405.803

- ❑ A Corrective Action Plan (CAP) must be submitted to CMS or its contractor, at the address indicated in the initial determination letter, **within 30 days of receipt of the initial determination.**
- ❑ CMS or its contractor will review the CAP and issue a written decision, **within 60 days of receipt of the CAP**, that either:
  - ❑ Reinstates the provider or supplier's billing privileges if the provider or supplier provides sufficient evidence to demonstrate compliance; or
  - ❑ Denies the CAP and, therefore, does not reinstate the provider or supplier's billing privileges.
- ❑ The denial of a CAP **is not** an initial determination under part 498 and therefore, **does not give rise to further appeal rights.**

# Reconsideration Requests

42 C.F.R. § 498.22

- ❑ Reconsideration requests must be submitted to CMS or its contractor **within 60 days of receipt of the initial determination.**
  - ❑ The date of receipt of the initial determination is presumed to be five days after the date on the notice unless there is a showing that it was, in fact, received earlier or later.
  - ❑ If the provider or supplier is unable to file the request within the 60 day timeframe, he/she/it may file a written request stating the reasons why the request was not filed timely. CMS will extend the time for filing a reconsideration request if the provider or supplier shows good cause for missing the deadline.
- ❑ Reconsideration requests must state the issues or facts with which the provider or supplier disagrees, as well as the reasons for disagreement.
- ❑ Lastly, reconsideration requests should include all written evidence and statements that are relevant to the basis for the initial determination. Unless an ALJ allows it, this is the only opportunity to submit new documentary evidence in the administrative appeals process.

# Representation for Provider Enrollment Appeals

42 C.F.R. § 498.10-11

- ❑ A provider or supplier may appoint anyone as its representative so long as the individual is not disqualified or suspended from acting as a representative in proceedings before the Secretary or otherwise prohibited by law.
  - ❑ If the representative appointed is not an attorney, the provider or supplier must file written notice of the appointment with CMS, the ALJ, or the Departmental Appeals Board.
- ❑ If the representative appointed is an attorney, the attorney's statement that he or she has the authority to represent the party is sufficient for CMS to recognize the appointment.



# Poll Question Four



Questions?

# Reconsidered Determination

42 C.F.R. § 498.24

- ❑ CMS will consider:
  - ❑ the initial determination;
  - ❑ the findings on which the initial determination was based;
  - ❑ the evidence considered in making the initial determination; and
  - ❑ any other written evidence submitted.
  
- ❑ CMS will then render a written decision, **within 90 days of receipt of the reconsideration request**, upholding or overturning the initial determination.

# ALJ Review

42 C.F.R. § 498.40

- ❑ Any provider or supplier that disagrees with a reconsideration decision is entitled to a hearing before an Administrative Law Judge (ALJ).
- ❑ The provider or supplier **must file the request in writing within 60 days from receipt of the notice of the reconsideration decision.**
- ❑ The request for an ALJ hearing must:
  - ❑ Identify the specific issues, and the findings of fact and conclusions of law with which the provider or supplier disagrees; and
  - ❑ Specify the basis for contending that the findings and conclusions are incorrect.
- ❑ If the request was not filed within 60 days:
  - ❑ The provider or supplier may file with the ALJ a written request for extension of time stating the reasons why the request was not filed timely.
  - ❑ The ALJ may extend the time for filing the request for hearing if good cause is shown.
- ❑ The ALJ must issue a written decision, dismissal order, or remand to CMS.

# Departmental Appeals Board Review

42 C.F.R. § 498.80-82

- ❑ CMS, as well as the provider or supplier, has a right to request Departmental Appeals Board (DAB) review of the ALJ's decision or dismissal order.
- ❑ The requesting party **must file the request within 60 days from receipt of the notice of decision or dismissal**, unless the Board extends the time for filing for good cause.
- ❑ A request for review of an ALJ decision or dismissal must:
  - ❑ specify the issues, the findings of fact or conclusions of law with which the party disagrees; and
  - ❑ the basis for contending that the findings and conclusions are incorrect.

# Judicial Review

42 C.F.R. § 498.95

- ❑ Any provider or supplier dissatisfied with DAB review has a right to seek judicial review of the DAB's decision.
- ❑ The provider or supplier must commence civil action within 60 days from receipt of the notice of the DAB's decision, unless the DAB extends the time.
  - ❑ The request for extension must be filed in writing with the DAB before the 60-day period ends.
  - ❑ For good cause shown, the DAB may extend the time for commencing civil action.

# Poll Question Five



Questions?



# Example 1

## Adverse Event

**Provider's** medical license was suspended by the State licensing authority and the provider failed to report this adverse action to CMS within the required timeframe.

(Reporting Periods by Regulation  
citation: 42 CFR §424.516)

## CMS Action

CMS Subsequently **revoked** this providers Medicare billing privileges for:

### **Noncompliance:**

#### **42 C.F.R. § 424.535(a)(1)**

as the provider did not hold a valid medical license

**(CAP and Reconsideration Appeal Rights Apply)**

### **Failure to Report**

#### **42 C.F.R. § 424.535(a)(9)**

as the provider did not report the medical license suspension to the MAC

**(Reconsideration Appeal Rights Apply)**

# Example 2

## Adverse Event

**Provider** submitted an 855 application, listing John Doe as its managing employee and reported no prior adverse actions.

**John Doe** was convicted of a healthcare fraud felony offense eight years prior to the submission of the application.

**CMS** detects the felony conviction after the enrollment was approved through ongoing provider screening.

## CMS Action

CMS Subsequently **revoked** this providers Medicare billing privileges for:

### False or Misleading Information:

#### **42 C.F.R. § 424.535(a)(4)**

as the provider omitted the managing employee's felony conviction on its revalidation application.

**(Reconsideration Appeal Rights Apply)**

### Felony Conviction:

#### **42 C.F.R. § 424.535(a)(3)**

as the managing employee has a felony conviction within the last 10 years

**(Reconsideration Appeal Rights Apply)**

**CMS** notifies the **State Medicaid Agencies** (SMA) to terminate the provider after the Medicare appeal is complete.

# Example 3

## Adverse Event

**Provider**, a physician group, initially enrolled with *123 Healthcare Lane, Anytown, DC 98765* reported as their practice location

**Provider** relocated their practice location to *456 New Site Drive, Anytown, DC 98765*

**Provider** failed to report their change of practice location within the required timeframe

(Reporting Periods by Regulation citation: [42 CFR §424.516](#))

## CMS Action

CMS Subsequently **revoked** this providers Medicare billing privileges for:

### Non-Operational:

#### **42 C.F.R. § 424.535(a)(5)**

as the provider was no longer operational at the address listed on its 855 application

**(Reconsideration Appeal Rights Apply)**

### Failure to Report:

#### **42 C.F.R. § 424.535(a)(9)**

as the provider did not report the change in practice location to the MAC

**(Reconsideration Appeal Rights Apply)**

**CMS** notifies the **State Medicaid Agencies (SMA)** to terminate the provider after the Medicare appeal is complete.



Questions?

# Thank You!

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