

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-08 Medicare Program Integrity</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 304</b>	<b>Date: September 25, 2009</b>
	<b>Change Request 6642</b>

**SUBJECT: Inter-Contractor Communication and Provider Enrollment Revocations**

**I. SUMMARY OF CHANGES:** This change request requires the contractor to notify other affected contractors when it revokes a provider or supplier's Medicare billing privileges.

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE: October 26, 2009**

**IMPLEMENTATION DATE: October 26, 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**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	10/13.2/Contractor Issued Revocations

**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: 304	Date: September 25, 2009	Change Request: 6642
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**SUBJECT: Inter-Contractor Communication and Provider Enrollment Revocations**

**Effective Date: October 26, 2009**

**Implementation Date: October 26, 2009**

## I. GENERAL INFORMATION

**A. Background:** This change request updates Pub. 100-08, chapter 10, section 13.2, to require that the contractor notify other affected contractors when it revokes a provider or supplier's Medicare billing privileges.

**B. Policy:** The purpose of this change request is to ensure that contractors effectively communicate with one another in cases where a provider or supplier is revoked from the Medicare program.

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
6642.1	If the contractor revokes a provider or supplier's Medicare billing privileges, the contractor shall determine, via a search of the Provider Enrollment, Chain and Ownership System (PECOS), whether the provider/supplier is enrolled with any other Medicare contractors.	X		X	X	X					
6642.2	If, pursuant to business requirement 6642.1, the contractor determines that the revoked provider/supplier is 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.	X		X	X	X					
6642.3	Upon receipt of this notification from the revoking contractor, the receiving contractor shall determine whether the provider or supplier's Medicare billing privileges should be revoked in its jurisdiction as well; should the contractor need assistance in making this determination, it may contact its Division of Provider and Supplier Enrollment liaison or business function lead.	X		X	X	X					

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	None										

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space:**

### V. CONTACTS

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

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

### 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.

## 13.2 – Contractor Issued Revocations

*(Rev.304, Issued: 09-25-09, Effective: 10-26-09, Implementation: 10-26-09)*

### A. Revocation Reasons

The contractor may issue a revocation using revocation reasons 1 through 11 below without prior approval from CMS. Sections 13.3 through 13.3.2 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 – 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 – The provider is no longer operational.

3 years – 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.