NATIONAL PROVIDER ENROLLMENT CONFERENCE

57 Million Patients, 2 Million Providers, ONE Mission

Maintaining Compliance with Enrollment Requirements and the Appeals Process

September 2017

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CMS
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Session Overview

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

Two Administrative Actions: Very Different Consequences

- **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:** "Pause button"
  - Provider or supplier must complete and submit a new enrollment application to reactivate its 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 AUTHORITY

14 Reasons for Revocation

42 C.F.R. §424.535(a)

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Re-Enrollment Bar

42 CFR §424.535(c)

- If a provider, supplier, owner, or managing employee has their billing privileges revoked, they are 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 C.F.R. §424.535(a)(1)

- 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 C.F.R. §424.535(a)(1)

- **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).
- **Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations:** 30 days for change of ownership. All other changes to the enrollment application must be reported within 90 days. *See* 42 C.F.R. § 424.516(d)(1)(i) and (d)(2).

Provider or Supplier Conduct

42 C.F.R. §424.535(a)(2)

- 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 C.F.R. §424.535(a)(3)

- 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 C.F.R. §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

Felonies

42 C.F.R. §424.535(a)(3)

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 C.F.R. §424.535(a)(3)

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

False or Misleading Information

42 C.F.R. §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
- Both initial application and any subsequent application
- Omission of information constitutes non-reporting
- Partial reporting or mischaracterization may constitute non-reporting
- Must report Adverse Legal Actions in applicable application portions
- Penalty is 3 year re-enrollment bar

Section 3 – Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, 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. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; 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 pre-trial diversions; 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); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Section 3 – Final Adverse Legal Actions/Convictions

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

Section 3 – Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 5 – Ownership Interest and/or Managing Control Information (Organizations)

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in Section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: *www.cms.hhs.gov/MedicareProviderSupEnroll*. If there is more than one organization that should be reported, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

Section 5 – Ownership Interest and/or Managing Control Information (Organizations)

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

B. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 5A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 6

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 6 – Ownership Interest and/or Managing Control Information (Individuals)

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll*.

The supplier MUST have at least ONE owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Section 6 – Ownership Interest and/or Managing Control Information (Individuals)

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

   ☐ YES–Continue Below ☐ NO–Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

On-site Review

42 C.F.R. §424.535(a)(5)

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

- No longer operational to furnish Medicare-covered items or services.
- Otherwise fails to satisfy any Medicare enrollment requirement.

Operational

42 CFR §424.502

- 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

DME Supplier: "Operational"-Requirements

42 C.F.R. § 424.57(c)(8)

- In addition to Operational definition at 42 C.F.R. § 424.502:
  - Maintains a practice location that is **at least 200 square feet** (some exceptions; *See* 42 C.F.R. § 424.57(c)(7)).
  - Maintains a **permanent visible sign in plain view** and **posts hours of operation**.
    - Within a building complex→ the sign must be visible at the main entrance of the building or the hours can be posted at the entrance of the supplier.
  - Is accessible and staffed during posted hours of operation

DME Supplier: "Operational"-Requirements (Cont.) 42 C.F.R. § 424.57(c)(8)

- In addition to Operational definition at 42 C.F.R. § 424.502:
  - Except for business records that are stored in centralized location (as described in paragraph 42 C.F.R. § 424.57(c)(7)(ii) is in a location that **contains space for storing business records** (including the supplier's delivery, maintenance, and beneficiary communication records).
  - Is in a location that contains **space for retaining the necessary ordering and referring documentation** specified in 42 C.F.R. § 424.516(f).

IDTF: "Operational"-Requirements

42 C.F.R. § 410.33(g)(14)

- In addition to Operational definition at 42 C.F.R. § 424.502:
  - Maintain a **visible sign posting its normal business hours**
  - With the exception of hospital-based and mobile IDTFs, a fixed-base IDTF is **prohibited** from the following:
    - Sharing a practice location with another Medicare-enrolled individual or organization;
    - Leasing or subleasing its operations or its practice location to another Medicare-enrolled individual or organization; or
    - Sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization.

Misuse of Billing Number

42 C.F.R. §424.535(a)(7)

- 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.
- Improper Locum Tenens
  - Locum tenens: A Medicare enrolled physician is unavailable and has another physician substitute for him/her to render a service(s).
- Improper "Incident to" services/billing
  - "Incident to": services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

Abuse of Billing Privileges

42 C.F.R. §424.535(a)(8)(i)

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 C.F.R. §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.

Abuse of Billing Privileges

42 C.F.R. §424.535(a)(8)(ii)

- 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.

Failure to Report

42 C.F.R. §424.535(a)(9)

- 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 C.F.R. §424.535(a)(10)

- **Who?**
  - **(1)** A provider or a supplier that **furnishes** covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services *OR* **(2)** 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 C.F.R. §424.535(a)(10)

- Provider/supplier must maintain documentation including written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.
- Provider/supplier must, upon the request of CMS or a Medicare contractor, provide access to said documentation
- Written request sent to correspondence address ***OR*** hand delivered request to correspondence address/practice location
- Request will specify the amount of days which are allotted for the production of documents to be considered timely

Medicaid Termination

42 C.F.R. §424.535(a)(12)

- 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" to be
- Common underlying reasons terminations are deemed "for cause" include adverse licensure actions, federal exclusions, fraudulent conduct, and abusive billing.

Prescribing Authority

42 C.F.R. §424.535(a)(13)

- 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 C.F.R. §424.535(a)(14)

- 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.**

Improper Prescribing Practices

42 C.F.R. §424.535(a)(14)(i) Threat to Health and Safety

- In making this determination, CMS considers the following factors:
  - **diagnoses** to support the prescriptions.
  - necessary evaluation of the patient **could not** have occurred
  - prescribed controlled substances in **excessive dosages→ patient overdoses**.
  - The number and type(s) of **disciplinary actions** taken by the licensing body or state medical board
  - **history of "final adverse actions**"
  - The number and type(s) of **malpractice suits**.
  - Whether any **State Medicaid program or any other public or private health insurance program** sanctions against prescribing
  - **Any other relevant information** provided to CMS.

Improper Prescribing Practices

42 C.F.R. §424.535(a)(14)(ii) Fails to Meet Medicare Requirements

- In making this determination, CMS considers the following factors:
  - Whether the physician or eligible professional has a pattern or practice of prescribing **without valid prescribing authority**.
  - Whether the physician or eligible professional has a pattern or practice of prescribing for controlled substances **outside the scope of the prescriber's DEA registration**.
  - Whether the physician or eligible professional has a pattern or practice of prescribing drugs for **indications that were not medically accepted** and whether there is evidence that the physician or eligible professional **acted in reckless disregard for the health and safety of the patient**.

DEACTIVATION AUTHORITY

Non-Billing

42 C.F.R. §424.540(a)(1)

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

Failure to Report

42 C.F.R. §424.540(a)(2)

- The provider or supplier does not 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. A change in ownership or control must be reported within 30 calendar days as specified in §§424.520(b) and 424.550(b).

Non-Response

42 C.F.R. §424.540(a)(3)

- The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

APPEALS

Appeal Rights

- For purposes of provider enrollment, **appeal rights extend from initial determinations,** including:
  - The **denial** of enrollment in the Medicare program
  - The **revocation** of Medicare billing privileges and any corresponding provider agreement or supplier agreement
  - The **effective date** of the approval of enrollment and any corresponding provider agreement or supplier agreement
- Providers and suppliers are advised of their appeal rights in the letter containing notification of the denial, revocation, or effective date.
- **Regulatory Authority**: Pursuant to 42 C.F.R. § 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

- **Corrective Action Plan (CAP)**
  - A CAP is the plan that 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 C.F.R. § 424.530 or in response to a revocation for noncompliance under 42 C.F.R. § 424.535(a)(1).
    - When submitting a CAP, a provider or supplier has only one opportunity to correct all deficiencies that served as the basis of the initial determination.
- **Reconsideration**
  - A reconsideration request allows the provider or supplier to demonstrate error in the initial determination, such as a revocation of billing privileges, at the time the initial determination was made.

Corrective Action Plans

- 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

- Must be submitted **within 60 days from receipt of the notice of 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, she/he/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.
- Must state the issues or facts with which the provider or supplier disagrees, as well as the reasons for disagreement.
- 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

- A provider or supplier may appoint as its representative anyone 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.

Reconsidered Determination

- 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.

Request for Hearing (ALJ Review)

- 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

- 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

- 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.

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)(1)
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 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!

August 2017 | This summary material was part of an in-person presentation. It was current at the time we presented it. It does not grant rights or impose obligations. We encourage you to review statutes, regulations, and other directions for details.

Please take a few moments and complete the assessment found here.

Centers for Medicare & Medicaid Services