CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 581	**Date: February 27, 2015**
	Change Request 9065

SUBJECT: Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to incorporate provisions in CMS-6045-F into Pub. 100-08, PIM, chapter 15. The CR also addresses several minor provider enrollment policy issues that have recently arisen.

EFFECTIVE DATE: May 28, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 28, 2015
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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15/1.1/Definitions
R	15/15/8.4/Denials
R	15/15/17/Establishing an Effective Date of Medicare Billing Privileges
R	15/15/24.9.1/Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers
R	15/15/25.1.1/Corrective Action Plans (CAPs)
R	15/15/25.2.1/Corrective Action Plans (CAPs)
R	15/15/27.2/Revocations
R	15/15/28/Deceased Practitioners

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 581	Date: February 27, 2015	Change Request: 9065

SUBJECT: Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

EFFECTIVE DATE: May 28, 2015
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I. GENERAL INFORMATION

A. Background: On December 5, 2014, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule (CMS-6045-F) titled "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment; Final Rule" (79 FR 72499). This final rule implemented several important program integrity enhancements. These include, but are not limited to: (1) expanding the instances in which a felony conviction can serve as a basis for denial or revocation of a provider's or supplier's enrollment; (2) enabling CMS to revoke Medicare billing privileges if it determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements; and (3) limiting the ability of ambulance suppliers to ``backbill'' for services performed prior to enrollment. This change request (CR) addresses several of the enhancements outlined in CMS-6045-F.

B. Policy: This CR: (1) incorporates certain provisions in CMS-6045-F into Pub. 100-08, PIM, chapter 15; and (2) addresses several minor provider enrollment policy issues that have recently arisen.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9065.1	If a supplier submits a corrective action plan (CAP) for a revocation based in part on 424.535(a)(1), the contractor shall (A) only consider the portion of the CAP pertaining to (a)(1); and (B) notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under § 405.879, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.		X							
9065.2	If a supplier submits a corrective action plan (CAP) for a		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	revocation based wholly or partly on and the CAP does not comply with section 15.25.1.1(A)(1) and (3), the contractor shall deny the CAP.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9065.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

15.1.1 – Definitions

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

Below is a list of terms commonly used in the Medicare enrollment process:

Accredited provider/supplier means a supplier that has been accredited by a CMS-designated accreditation organization.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic Resonance Imaging (MRI).
(ii) Computed Tomography (CT).
(iii) Nuclear Medicine.
(iv) Positron Emission Tomography (PET).

Applicant means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized official means an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Billing agency means an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services. In order to receive payment directly from Medicare on behalf of a provider or supplier, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act. (For further information, see CMS Publication 100-04, chapter 1, section 30.2.4.)

Change in majority ownership occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a home health agency (HHA) during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

Change of ownership (CHOW) is defined in 42 CFR §489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated official means an individual who is delegated by the "Authorized Official" the authority to report changes and updates to the provider/supplier's enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges.

Enroll/Enrollment means the process that Medicare uses to *establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services.*

Enrollment application means a paper CMS-855 enrollment application or the equivalent electronic enrollment process approved by the Office of Management and Budget (OMB).

Final adverse action means one or more of the following actions:

(i) A Medicare-imposed revocation of any Medicare billing privileges;

(ii) Suspension or revocation of a license to provide health care by any State licensing authority;

(iii) Revocation or suspension by an accreditation organization;

(iv) A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

(v) An exclusion or debarment from participation in a Federal or State health care program.

Immediate family member or member of a physician's immediate family means – under 42 CFR § 411.351 - a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Institutional provider means – for purposes of the Medicare application fee only - any provider or supplier that submits a paper Medicare enrollment application using the Form CMS–855A, Form CMS–855B (not including physician and non-physician practitioner organizations), Form CMS–855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application.

Legal business name is the name that is reported to the Internal Revenue Service (IRS).

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

Medicare identification number - For Part A providers, the Medicare Identification Number (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the NSC**.** (Note that for Part B and DMEPOS suppliers, the Medicare Identification Number may sometimes be referred to as the Provider Transaction Access Number (PTAN).)

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).

Operational – under 42 CFR §424.502 – means that the provider or supplier has a qualified physical practice location; is open to the public for the purpose of providing health care related services; is prepared to submit valid Medicare claims; and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124(A) of the Social Security Act.

Ownership or investment interest – under 42 CFR § 411.354(b) – means an ownership or investment interest in the entity that may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in any entity that furnishes designated health services.

Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Social Security Act.

Physician-owned hospital – under 42 CFR § 489.3 – means any participating hospital in which a physician, or an immediate family member of a physician, has a direct or indirect ownership or investment interest, regardless of the percentage of that interest.

Physician owner or investor – under 42 CFR § 411.362(a) – means a physician (or an immediate family member) with a direct or an indirect ownership or investment interest in the hospital.

Prospective provider means any entity specified in the definition of "provider" in 42 CFR §498.2 that seeks to be approved for coverage of its services by Medicare.

Prospective supplier means any entity specified in the definition of "supplier" in 42 CFR §405.802 that seeks to be approved for coverage of its services under Medicare.

Provider is defined at 42 CFR §400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Reassignment means that an individual physician, non-physician practitioner, or other supplier has granted a Medicare-enrolled provider or supplier the right to receive payment for the physician's, non-physician practitioner's or other supplier's services. (For further information, see § 1842(b)(6) of the Social Security Act, the Medicare regulations at 42 CFR §§424.70 - 424.90, and CMS Publication 100-04, chapter 1, sections 30.2 – 30.2.16.)

Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Supplier is defined in 42 CFR § 400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Tax identification number means the number (either the Social Security Number (SSN) or Employer Identification Number (EIN)) that the individual or organization uses to report tax information to the IRS.

15.8.4 – Denials

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

A. Denial Reasons

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter 15 as the basis for denial. Except in the situations outlined in section 15.8.4(B) below, the contractor may issue a denial without prior approval from CMS Central Office's provider enrollment unit (COPEU).

If the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the State/Regional Office (RO). The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider. The contractor shall copy the State and the RO on said letter.

Denial Reason 1 (42 CFR §424.530(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance *with the enrollment requirements in subpart P (of Part 424) o*r on 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. Such non-compliance includes, but is not limited to, the following situations:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 15.4.8 of this chapter for examples of suppliers that are not eligible to participate.)

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

g. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

NOTE: The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

Denial Reason 2 (42 CFR §424.530(a)(2)) – Excluded/Debarred from Federal Program

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 who is required to be reported on the CMS-855 is—

- Excluded from Medicare, Medicaid, or 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 Social Security Act, or

- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

Denial Reason 3 (42 CFR §424.530(a)(3)) – Felony Conviction

The provider, supplier, or any owner *or managing employee* of the provider or supplier *was*, *within the preceding* 10 years, *c*onvicted *(as that term is defined in 42 CFR § 1001.2)* of a *f*ederal or *s*tate felony offense that CMS determin*es* to be detrimental to the best interests of the *Medicare* program and its beneficiaries. Offenses include*, but are not limited in scope and severity to:*

- 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.

- 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.

- 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 outlined in section 1128 of the Social Security Act.

While, as discussed in section 15.27.2(D) of this chapter, a re-enrollment bar will be established for providers and suppliers whose billing privileges are revoked, this does not preclude the contractor from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact COPEU via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox for guidance.

Denial Reason 4 (42 CFR §424.530(a)(4)) – False or Misleading Information on Application

The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program.

Denial Reason 5 (42 CFR §424.530(a)(5)) – On-Site Review/Other Reliable Evidence that Requirements Not Met

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

(i) Is not operational to furnish Medicare-covered items or services; or

(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

Denial Reason 6 (42 CFR §424.530(a)(6)) – Existing Overpayment at Time of Application

(i) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof has an existing Medicare debt.

(ii) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:

(A) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination or revocation.

(B) The Medicare debt has not been fully repaid.

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse. In making this determination under § 424.530(a)(6)(ii), CMS considers the following factors:

(1) The amount of the Medicare debt.
(2) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.
(3) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.
(4) Whether the Medicare debt is currently being appealed.
(5) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.

A denial of Medicare enrollment under paragraph (a)(6) can be avoided if the enrolling provider, supplier or owner thereof does either of the following:

(A) Satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or

(B) Repays the debt in full.

Denial Reason 7 (42 CFR §424.530(a)(7)) – Medicare Payment Suspension

The current owner (as defined in §424.502), physician or non-physician practitioner has been placed under a Medicare payment suspension as defined in § 405.370 through § 405.372.

Denial Reason 8 (42 CFR §424.530(a)(8)) – Home Health Agency (HHA) Capitalization

An HHA submitting an initial application for enrollment:

- Cannot, within 30 days of a CMS or Medicare contractor request, furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement in 42 CFR §489.28(a); or

- Fails to satisfy the initial reserve operating funds requirement in 42 CFR §489.28(a).

Denial Reason 9 (42 CFR §424.530(a)(9)) – Hardship Exception Denial and Fee Not Paid

The institutional provider's (as that term is defined in 42 CFR §424.502) hardship exception request is not granted, and the institutional provider does not submit the required application fee within 30 days of notification that the hardship exception request was not approved.

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use 42 CFR §424.530(a)(1) as a basis for denial when the institutional provider:

- Does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes, or

- Submits the fee, but it cannot be deposited into a government-owned account.)

Denial Reason 10 (42 CFR §424.530(a)(10)) – Temporary Moratorium

The provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium. (This denial reason applies to initial enrollment applications and practice location additions.)

Denial Reason 11 (42 CFR § 424.530(a)(11)) – DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or

(ii) The applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

B. Denial Letters

1. General

When a decision to deny is made, the contractor shall send a letter to the provider identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of those shown in section 15.24 et seq. of this chapter. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier:

- No later than 5 business days after the contractor concludes that the provider or supplier's application should be denied, or

- If the denial requires prior COPEU authorization, no later than 5 business days after COPEU notifies the contractor of such authorization.

No reenrollment bar is established for denied applications. Reenrollment bars apply only to revocations.

2. Prior COPEU Approval

Prior to sending the denial letter, the contractor shall obtain approval of both the denial and the denial letter from its PEBFL if the denial involves any of the following situations:

- Situation (d), (e), (g) or (h) under Denial Reason 1 above.
- § 424.535(a)(2), (a)(3), (a)(4), *(a)(6)* or (a)(11).

C. Post-Denial Submission of Enrollment Application

A provider or supplier that is denied enrollment in the Medicare program may not submit a new enrollment application until either of the following has occurred:

- If the denial was not appealed, the provider or supplier's appeal rights have lapsed, or
- If the denial was appealed, the provider or supplier has received notification that the determination was upheld.

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.

As stated in 42 CFR §424.530(c), if the denial was due to adverse activity (e.g., exclusion, 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, the denial 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 denial notification.

E. Other Impacts of a Denial

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor denies a change of information or CHOW submission per this section 15.8.4 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its (PEBFL) notifying him or her of the denial. COPEU will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Denial, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it per section 15.8.1 of this chapter, or rejects it per section 15.8.2 of this chapter, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. COPEU will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor denies a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor denies a revalidation application per this section 15.8.4, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall revoke the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) denies it again, (2) returns it per section 15.8.1 of this chapter, or (3) rejects it per section 15.8.2 of this chapter, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – revoke the provider's billing privileges, assuming the applicable time period has expired.

F. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

G. Final Adverse Actions

See section 15.5.3 of this chapter for information regarding the circumstances in which the contractor shall refer final adverse actions to COPEU via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox.

15.17 – Establishing an Effective Date of Medicare Billing Privileges

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

(This section only applies to the following individuals and organizations: physicians; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; *p*hysician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified *above; or ambulance suppliers.*

A. Background

In accordance with 42 CFR § 424.520(d), the effective date for the individuals and organizations identified above is the later of:

- The date the *supplier* filed an enrollment application that was subsequently approved, or
- The date the *supplier* first began furnishing services at a new practice location.

NOTE: The date of filing for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

B. Retrospective Billing

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

- The supplier has met all program requirements, including *s*tate 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 contractor shall interpret the phase "circumstances precluded enrollment" to mean that the *supplier* meets all program requirements (including *s*tate licensure) during the 30-day period before an application was submitted and no final adverse action, as identified i*n §* 424.502, precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment Business Function Lead for a determination on this issue.

C. Legal Distinction between Effective Date of Enrollment and retrospective Billing Date

The effective date of enrollment is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days

prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a Form CMS-855I initial enrollment application on May 1. The application is approved on June 1. The physician's effective date of enrollment is May 1, which is the later of: (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 1 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR §424.521(a) are met.

NOTE: However, that the effective date entered into the Provider Enrollment, Chain and Ownership System (PECOS) and the Multi-Carrier System will be April 1 and that claims submitted for services provided before April 1 will not be paid.

15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

[Month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR § 424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program*, and if this revocation is based in whole or in part on § 424.535(a)(1)*, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. *(Per 42 CFR § 405.879, a CAP cannot be accepted for revocations based exclusively on reasons other than § 424.535(a)(1). If the revocation is for multiple reasons of which one is § 424.535(a)(1), the CAP will only be reviewed with respect to the § 424.535(a)(1) basis for revocation.)* The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed and dated by the authorized or delegated official within the entity. CAP requests should be sent to:

[Name of MAC]		[Centers for Medicare & Medicaid Services]
[Address]	or	[Provider Enrollment Operations Group]
[City], ST [Zip]		[7500 Security Blvd.]
		[Mailstop: AR-18-50]
		[Baltimore, MD 21244-1850]

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

The reconsideration request should be sent to:

[Name of MAC]
[Address]
[City], ST [Zip]

Pursuant to 42 CFR §424.535(c), [Contractor name] is establishing a re-enrollment bar for a period of [Insert amount of time]. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.25.1.1 – Corrective Action Plans (CAPs)

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

A. Requirements and Submission of CAPs

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;

(4) For *r*evocation*s*, be based on *§ 424.535(a)(1). Consistent with § 405.879, CAPs for revocations based on grounds other than § 424.535(a)(1)* shall not be accepted. *(For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.)* If the supplier *submits a CAP that does not comply with this paragraph*, the contractor shall notify the supplier via letter or e-mail that it cannot be considered. *(If multiple grounds are involved of which one is (a)(1), the contractor shall:*

- *Only consider the portion of the CAP pertaining to (a)(1), and*
- *Notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under § 405.879, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.)*

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above*:*

- *Denials - T*he contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.
- *Revocations – The contractor shall not contact the supplier for the missing information or documentation. It shall simply deny the CAP. (Under § 405.879(a)(2), the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.)*

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP.

B. Processing and Approval of CAPs

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless

stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements. Consider the following examples:

1. Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

2. Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

C. Concurrent Submission of CAP and Reconsideration Request

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It cannot be appealed.
- The contractor shall notify the supplier of the denial via letter.
- The supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if submitted, shall be processed.

15.25.2.1 – Corrective Action Plans (CAPs)

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

A. Submission of CAPs

The CAP process gives a provider or supplier (hereinafter collectively referred to as "providers") an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(4) For revocations, be based on *§ 424.535(a)(1). Consistent with § 405.879, CAPs for revocations based on grounds other than § 424.535(a)(1)* cannot be accepted. *(For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) CMS Central Office's Provider Enrollment Unit (COPEU)*, which processes all CAPs, will notify the provider *if a* CAP cannot be accepted.

CAP requests must be sent to the following address:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group
7500 Security Boulevard
Mailstop AR 18-18-50
Baltimore, MD 21244-1850

If the contractor inadvertently receives a CAP request, it shall immediately forward it to *COPEU* at this address or, if possible, to the following *COPEU* mailbox: providerenrollmentappeals@cms.hhs.gov.

Also:

- PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

- The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

B. Processing and Approval of CAPs

COPEU will process a CAP within 60 days. During this period, *COPEU* will not toll the filing requirements associated with a reconsideration request.

If *COPEU* approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and issue or restore billing privileges (as applicable), and (2) notify the provider thereof via letter. If applicable, *COPEU* will also notify the contractor of the effective date.

If *COPEU* denies a CAP, it will notify the provider via letter, on which the contractor will be copied.

15.27.2 – Revocations

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

A. Revocation Reasons

(The contractor shall not issue any revocation or revocation letter without prior approval from CMS Central Office's provider enrollment unit (COPEU).)

When drafting a revocation letter (which, in all cases, must be sent to COPEU via the ProviderEnrollmentRevocations@cms.hhs.gov for approval), the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.535(a)(1)) into the letter. The contractor shall not use provisions from this chapter as the basis for revocation.

1. Revocation Reason 1 (42 CFR § 424.535(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements *in subpart P (of Part 424)* 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. *The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.*

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.

Other situations in which § 424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.

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

g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (This revocation reason will not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason §424.540(a)(3) in lieu thereof.)

h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

NOTE: The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

2. Revocation Reason 2 (42 CFR §424.535(a)(2)) – Excluded/Debarred from Federal Program

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, the contractor shall notify its PEBFL immediately. COPEU will notify the Contracting Officer's Representative (COR) for the appropriate Zone Program Integrity Contractor. The COR will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

3. Revocation Reason 3 (42 CFR §424.535(a)(3)) – Felony Conviction

The provider, supplier, or any owner *or managing employee* of the provider or supplier *was*, *within the preceding* 10 years, *c*onvicted *(as that term is defined in 42 CFR § 1001.2)* of a *f*ederal or *s*tate felony offense that CMS determin*es* to be detrimental to the best interests of the *Medicare* program and its beneficiaries. Offenses include*, but are not limited in scope and severity to:*

(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.

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 that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all criteria necessary to enroll in Medicare.

4. Revocation Reason 4 (42 CFR §424.535(a)(4)) – False or Misleading Information on Application

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.)

5. Revocation Reason 5 (42 CFR §424.535(a)(5)) - On-Site Review/Other Reliable Evidence that Requirements Not Met

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

(i) Is not operational to furnish Medicare-covered items or services; or

(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

6. Revocation Reason 6 (§424.535(a)(6)) - Hardship Exception Denial and Fee Not Paid

(i) (A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or

(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(ii) (A) Either of the following occurs:

(1) CMS is not able to deposit the full application amount into a government-owned account; or

(2) The funds are not able to be credited to the United States Treasury;

(B) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

7. Revocation Reason 7 (42 CFR §424.535(a)(7)) – Misuse of Billing Number

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 that 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.

8. Revocation Reason 8 (42 CFR §424.535(a)(8)) – Abuse of Billing Privileges

Abuse of billing privileges includes either of the following:

(i) 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:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(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 factors:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) 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.

*(**NOTE**: With respect to (a)(8), CMS Central Office -- rather than the contractor -- will (1) make all determinations regarding whether a provider or supplier has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; (3) accumulate all information needed to make such determinations; and (4) prepare and send all revocation letters.)*

9. Revocation Reason 9 (42 CFR §424.535(a)(9)) – Failure to Report Changes

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.

With respect to Revocation Reason 9:

- 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 pursue a revocation 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 pursue a revocation (e.g., seeking COPEU's approval to revoke).

10. Revocation Reason 10 (42 CFR §424.535(a)(10)) – Non-Compliance with Documentation Requirements

The provider or supplier did not comply with the documentation requirements specified in 42 CFR §424.516(f).

11. Revocation Reason 11 (42 CFR §424.535(a)(11)) - Home Health Agency (HHA) Capitalization

A home health agency (HHA) fails to furnish - within 30 days of a CMS or Medicare contractor request - supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR §489.28(a).

12. Revocation Reason 12 (42 CFR §424.535(a)(12)) – Medicaid Billing Privileges Revoked

The provider or supplier's Medicaid billing privileges are terminated or revoked by a State Medicaid Agency.

(Medicare may not terminate a provider or supplier's Medicare billing privileges unless and until the provider or supplier has exhausted all applicable Medicaid appeal rights).

13. Revocation Reason 13 (42 CFR § 424.535(a)(13)) - DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or

(ii) 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.

14. Revocation Reason 14 (42 CFR § 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:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements.

B. Prior COPEU Approval

Prior to sending any revocation letter (regardless of the basis for the revocation), the contractor shall obtain approval of both the revocation and the revocation letter from COPEU via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox.

During this review, CMS will also determine (1) the extent to which the revoked provider or supplier's other locations are affected by the revocation, (2) the geographic application of the reenrollment bar, and (3) the effective date of the revocation. CMS will notify the contractor of its determinations and instruct the contractor as to how to proceed.

C. Effective Date of Revocations

Per 42 CFR § 424.535(g), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. However, 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:** In accordance with 42 CFR § 424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization 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 PEBFL 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 (with prior COPEU approval) 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 revocation letter. It is up to the provider/supplier to furnish this data on its own volition.

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

D. Re-enrollment Bar

As stated in 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 effective date of the revocation until the end of the re-enrollment bar. *The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. (Felony convictions, however, always entail a 3-year bar.)* Per § 424.535(c), *t*he reenrollment bar does not apply if the revocation (1) is based on § 424.535(a)(1), and (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be *applied.*

The contractor shall update the Provider Enrollment, Chain and Ownership System (PECOS) to reflect that the individual is prohibited from participating in Medicare for the applicable 1, 2, or 3-year period.

(NOTE: Reenrollment bars apply only to revocations, not to denials. The contractor shall not impose a reenrollment bar following a denial of an application.)

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEBFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

- John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under § 424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.

- Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under § 424.535(a)(7), the contractor receives an

initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

- John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located, and John Smith is listed as a 75 percent owner.

E. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR § 424.535(h), *a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the later of: (1) the effective date of the revocation, or (2) the date that the HHA's last payable episode ends.*

Nothing in 42 CFR § 424.535(h) impacts the requirements of § 424.44 regarding the timely filing of claims.

F. Timeframe for Processing of Revocation Actions

If the contractor receives approval from COPEU (or receives an unrelated request from COPEU) to revoke a provider or supplier's billing privileges, the contractor shall complete all steps associated with the revocation no later than 5 business days from the date it received COPEU's approval/request. The contractor shall notify COPEU that it has completed all of the revocation steps no later than 3 business days after these steps have been completed.

G. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

H. 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:

- Preparing a draft revocation letter;
- E-mailing the letter to COPEU via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;
- Receiving COPEU's determinations and abiding by COPEU's instructions regarding the case;
- If COPEU authorizes the revocation:
    - Revoking the provider's billing privileges back to the appropriate date;
    - Establishing the applicable reenrollment bar;
    - Updating PECOS to show the length of the reenrollment bar;

- Assessing an overpayment, as *applicable; a*nd
- Affording appeal rights.

I. Reporting Revocations/Terminations to the State Medicaid Agencies and Children's Health Program (CHIP)

Section 6401(b)(2) of the Patient Protection and Affordable Health Care Act (i.e., the Affordable Care Act), enacted on March 23, 2010, requires that the Administrator of CMS establish a process for making available to each State Medicaid Plan or Child Health Plan the name, National Provider Identifier, and other identifying information for any provider of medical or other items or services or supplier who have their Medicare billing privileges revoked or denied.

To accomplish this task, CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. The contractor shall access this list on the 5th day of each month through the Share Point Ensemble site. The contractor shall review the monthly revoked and denied provider list for the names of Medicare providers revoked and denied in PECOS. The contractor shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier's revocation or denial.

The contractor shall update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. The contractor shall not make any other modifications to the format of this form or its contents. The following terms are the only authorized entries to be made on the report:

Appeal Submitted:
Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)
No - (definition: no appeal of any type has been submitted)

Appeal Type:
CAP
Reconsideration
ALJ
DAB

Appeal Status:
Under Review
Revocation Upheld
Revocation Overturned
Denial Upheld
Denial Overturned
CAP accepted
CAP denied
Reconsideration Accepted
Reconsideration Denied

If a contractor is reporting that no appeal has been submitted, the appeal type and status columns will be noted as N/A.

If an appeal action has been submitted to COPEU for certified providers or suppliers, contractors shall access the PEOG appeal's log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to its designated PEBFL.

J. Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- E-mail a copy of the revocation letter to the applicable RO's Division of Survey & Certification corporate mailbox. (The RO will notify the state of the revocation.)

- After determining the effective date of the revocation, end-date the entity's enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in the same manner as it would upon receipt of a tie-out notice from the RO.

- Afford the appropriate appeal rights per section 25 of this chapter.

15.28 – Deceased Practitioners

(Rev.581, Issued: 02- 27-15, Effective: 05-28-15, Implementation: 05-28-15)

A. Reports of Death from the Social Security Administration (SSA)

Contractors, including DME MACs and the NSC MAC, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities described below.

B. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners and/or Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

*(*If the person is an owner, managing employee, director, officer, authorized official, etc., the contractor shall verify and document that the person is deceased using th*e p*rocess described in *section (C)(1)* above.*)*

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with *which* the individual is associated that it needs to submit a *Form* CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If *the* provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR § 424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR § 424.57(c)(2).)

The contractor need not, however, solicit a *Form* CMS-855 change request if:

- The associate was the sole owner of his or her professional corporation or professional association. The contractor can simply take steps to *deactivate* that organization's enrollment in Medicare *pursuant to section 15.27 of this chapter (e.g., seeking CMS approval);* or

- The organization is enrolled with another contractor. Here, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section *15.28.*

C. Reports of Death from Third-Parties

1. Verification

If a contractor, including DME MACs or the NSC MAC, receives a report of death from a third-party (*s*tate provider association, *s*tate medical society, academic medical institution, etc.), the contractor shall verify that the *physician,* non-physician practitioner or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the *physician*, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits*;*

- Obtaining an obituary notice from the newspaper*;*

- Obtaining oral or written confirmation from the *s*tate licensing board (e.g., telephone, e-mail, computer screen printout)*;*

- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or

- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

2. Post-Confirmation Actions

Once the contractor verifies the death, it shall:

1. Undertake all actions normally associated with the *deactivation* of a supplier's billing privileges.

2. Search PECOS to determine whether the individual is listed therein as an owner, managing employee, director, officer, partner, authorized official, or delegated official *of another supplier*.

3. If the person is not in PECOS, no further action with respect to that individual is needed.

4. If the supplier is indeed identified in PECOS as an owner, officer, etc., the contractor shall notify the organization with *which* the person is associated that it needs to submit a *Form* CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance wit*h § *424.540(a)(2). *(*DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance wit*h § *424.57(c)(2).*)*

The contractor need not, however, ask for a *Form* CMS-855 change request if:

a. The *physician,* non-physician practitioner or DMEPOS supplier was the sole owner of his/hers professional corporation or professional association. The contractor can simply take steps to *deactivate* that organization's enrollment in Medicare *pursuant to section 15.27 of this chapter* ; or

b. The organization is enrolled with another contractor. In this situation, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section *15.28.*

The contractor shall place verification documentation in the provider or supplier file in accordance with section *15.7.3* of this chapter.

D. Education & Outreach

Contractors, including DME MACs and the NSC MAC, shall conduct outreach to *s*tate provider associations, *s*tate medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death *of* physicians *and* non-physician practitioners participating in the Medicare program.

E. Trustees/Legal Representatives

1. NPI - The trustee/legal representative of a deceased *physician*, non-physician practitioner or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.

2. Special Payment Address - In situations where a *physician*, non-physician practitioner or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the *physician*, non-physician practitioner or DMEPOS supplier's estate to change the

physician, non-physician practitioner or DMEPOS supplier's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- *Form* CMS-855 change of information request that updates the "Special Payment" address in the application. The *Form* CMS-855 can be signed by the trustee/legal representative.

- Any evidence – within reason - verifying that the *physician*, non-physician practitioner or DMEPOS supplier is in fact deceased.

- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner or DMEPOS supplier's estate.

The policies in this section *15.28*(E)(1) and (2) apply only to *physicians*, non-physician practitioners and DMEPOS suppliers who operated their business as sole proprietors. It does not apply to solely-owned corporations, limited liability companies, etc., *nor to* situations in which the *physician or* non-physician *practitioner r*eassigned his or her benefits to another entity.