CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 214	Date: JUNE 29, 2007
	Change Request 5504

SUBJECT: Clarification of Provider Enrollment Revocations

I. SUMMARY OF CHANGES: This change request revises and updates Pub. 100-08, chapter 10, to furnish additional clarification to Medicare contractors on the handling of provider enrollment revocations. Clarification is also provided regarding the rejection of CMS-855 provider enrollment applications.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JULY 2, 2007
IMPLEMENTATION DATE: July 30, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/1.3/Medicare Contractor Duties
R	10/3.1/Pre-Screening Process
R	10/13.1/CMS or Contractor Issued Deactivations
R	10/13.2/Contractor Issued Revocations
N	10/13.3.1/PSC Identified Revocations
N	10/13.3.2/CMS Satellite Office or Regional Office Identified Revocations
D	10/13.4/PSC Identified Revocations
D	10/13.5/CMS Satellite Office or Regional Office Identified Revocations

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:
Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 214	Date: June 29, 2007	Change Request: 5504

SUBJECT: Clarification of Provider Enrollment Revocations

EFFECTIVE DATE: **July 2, 2007**
IMPLEMENTATION DATE: July 30, 2007

I. GENERAL INFORMATION

A. Background: This change request revises and updates Pub. 100-08, chapter 10, section 13.2 in order to furnish additional clarification to Medicare contractors on the handling of provider enrollment revocations. Clarification is also provided regarding the rejection of CMS-855 provider enrollment applications and the training of provider enrollment personnel. (A number of minor editorial corrections are addressed as well, including a change in the title of Pub. 100-08, chapter 10, section 13.1.)

B. Policy: The purpose of this change request is to clarify various questions that have arisen regarding provider enrollment revocations and rejections.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5504.1	The contractor shall develop (and regularly update) a written training guide for new and current employees on the proper processing of CMS-855 applications as well as the appropriate entrance of data into PECOS.	X		X	X		X					
5504.2	The contractor shall note that the 60-day timeliness clock identified in Pub. 100-08, chapter 10, section 3.1 begins on the date the contractor sent the pre-screening letter to the provider; if the contractor makes a follow-up request for additional information, the 60-day clock does not begin anew, but continues running from the date the pre-screening letter was sent.	X		X	X		X					NSC
5504.3	Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	Division of Provider and Supplier Enrollment (DPSE) contractor liaison within 20 calendar days of the end of each quarter in which deactivations occurred (i.e., January, April, July, and October).											
5504.4	The contractor shall note that revocations issued by a contractor other than the National Supplier Clearinghouse (NSC) become effective within 30 days of the initial revocation notification; revocations issued by the NSC become effective 15 days after the entity is sent notice of the revocation.	X		X	X		X					NSC
5504.5	Prior to issuing a revocation for a Part A provider or a certified Part B supplier, the contractor shall notify the Division of Provider and Supplier Enrollment (DPSE), as well as the applicable regional office's survey and certification contact person.	X		X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

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

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):***

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Medicare Program Integrity Manual
Chapter 10 - Healthcare Provider/Supplier Enrollment

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(Rev. 214; 06-29-07)

1.3 – Medicare Contractor Duties

(Rev. 214; Issued: 06-29-07; Effective: 07-02-07; Implementation Date: 07-30-07)

The contractor must adhere to the processing guidelines established in this chapter 10 (hereinafter generally referred to as "this manual"). In addition, *the contractor* shall assign the appropriate number of staff to the Medicare enrollment function to meet established processing *timeframes*.

The contractor shall provide training to new employees and provide refresher training, as necessary, to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program;
- A review of applicable regulations, manual instructions and other guidance issued by CMS;
- A review of the contractor's enrollment processes and procedures; and
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, *the* contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst;
- Test the new employee to ensure that the analyst understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS; and
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy and contractor procedures.

Moreover, each contractor shall develop (and update as needed) a written training guide for new and current employees on the proper processing of CMS-855 applications as well as the appropriate entrance of data into PECOS.

Conduct Prescreening

- Review the application to determine that it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate enrollment application.

Conduct Verification, Validation, and Final Processing

- Verify and validate the information collected on the enrollment application.

- Coordinate with State survey/certification agencies and regional offices (ROs), as needed.

- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes. The change request signature must be checked against the original signature to determine the validity of any change to EFT information. This check can be made against a digital/photo image kept in-house. (See section 8 of this manual for more information.)

- Confirm that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG). Contractors shall confirm and validate data through Qualifier.net, the Medicare Exclusion Database (MED), and the General Services Administration (GSA) debarment list, in accordance with existing CMS instructions and directives.

- Confirm that *enrolled suppliers* are reviewed monthly against the MED. This is to ensure that billing privileges are not retained by providers/suppliers that become excluded after enrollment. (This task only applies to carriers.)

- Review and investigate provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines.

Coordinate with other Contractors

- The NSC shall maintain a national master file of all durable medical equipment suppliers and share that information with the durable medical equipment regional contractors.

Use of and Establishment of Records in PECOS

- Establish, update and close provider and supplier records in PECOS.

3.1 – Pre-Screening Process

(Rev. 214; Issued: 06-29-07; Effective: 07-02-07; Implementation Date: 07-30-07)

A. Initial 15-Day Review

Within 15 calendar days after the application is received in the contractor's mailroom, the contractor shall complete a "pre-screen" of the application. The purpose of the pre-screening process is to ensure that the provider, at the time the application was originally submitted:

- Completed all required data elements on the application, regardless of the materiality of the data element or whether the information furnished is correct.

- Furnished all required supporting documentation – including, but not limited to, medical or professional licenses, certifications and registrations required by Federal or State law; NPI notification letters from NPPES; business licenses; IRS CP-575 documentation; interim sales agreements; etc. – needed to process the requested enrollment action.

If the provider: (1) files an application with at least one missing required data element, or (2) fails to submit all required supporting documentation, the contractor shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the elements listed below. (The letter must be sent within the aforementioned 15-day period.)

- A list of all missing data or documentation;

- A request that the provider submit the data within a contractor-specified timeframe (i.e., the contractor can use whatever timeframe it wants, so long as it is within reason);

- The CMS Web site at which the CMS-855 forms can be found. The contractor shall instruct the provider to print out the page(s) containing the missing data; to enter the data on the blank page; to sign and date a new, blank certification statement; and to send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.

If the only missing material is documentation (i.e., all data elements have been completed), the contractor can forgo the activities in the previous paragraph. No newly-signed certification statement is required.

- A fax number and mailing address to which the missing data or documentation can be sent.

Note that the pre-screening letter is the only request for missing information or missing documentation that the contractor must make. Obviously, the contractor should respond

to any of the provider's telephone calls, e-mails, etc., resulting from the pre-screening letter. However, the contractor need not – on its own volition – make an additional request for the missing data or documentation.

In addition:

- **Missing Information Available Elsewhere** – Even if the provider's application contains missing information that is nevertheless detected elsewhere on the form, in the supporting documentation, or on another enrollment form, the contractor must still send a pre-screening letter requesting the provider to furnish the missing data on the CMS-855. (An example would be if the provider neglected to furnish its zip code but the zip code is clearly indicated on a supporting document; another illustration would be if the provider failed to check the reason why the application was submitted yet it is patently obvious to the contractor that it is an initial enrollment.)

- **Unsolicited Submission of Data** - If the provider later submits the missing data on its own volition (i.e., without being contacted by the contractor) prior to the date the contractor finishes prescreening, the contractor shall include this additional data in its prescreening review.

- **Relationship to the Verification Process –** It is important that the contractor review section 5.3 of this manual for information on requesting additional (or "clarifying") information and how this is tied to the pre-screening process.

B. Rejection

In accordance with 42 CFR § 424.525(a), the contractor may reject the provider's application if the provider fails to furnish all of the information and documentation requested in the pre-screening letter within 60 calendar days of the contractor's request for the data. *The 60-day clock starts on the date the pre-screening letter was sent to the provider. If the contractor makes a follow-up request for information, the 60-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. To illustrate, suppose the contractor sent out a pre-screening letter on March 1, thus triggering the 60-day clock. The provider sent in most, but not all of the requested data. Though not required to make an additional contact beyond the pre-screening letter, the contractor telephoned the provider on March 25 to request the missing data. The provider failed to respond. The contractor can reject the application on April 30, which is 60 days after the initial request.*

***NOTE:** Per 42 CFR § 424.525(b), the contractor has the discretion to extend this 60-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues. However, if the contractor elects to extend the 60-day period, this does not stop or restart the 60-day clock; in other words, the clock keeps running from the date the initial request for information was made.*

The contractor shall also note the following with respect to rejections:

- **PECOS** – The contractor shall create an L & T record within the 15-day period prescribed in sections 2.3 and 15 of this manual. If the contractor rejects the application and was unable to create an L & T record due to missing data, the contractor shall document the provider file accordingly. If the contractor was able to create the L & T record but rejected the application, the contractor shall flip the status to "rejected" in PECOS.

- **Resubmission after Rejection** – If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.

- **Appeals** – The provider may not appeal a rejection of its enrollment application.

- **Policy Application –** Unless stated otherwise in this manual, the policies contained in this section 3.1 apply to all CMS-855 applications identified in sections 2.1 and 2.2 above (e.g., changes of information, reassignments). Thus, suppose an enrolled provider submits a CMS 588. If any information is missing from the form, the contractor shall send a pre-screening letter to the provider.

- **Good-Faith Effort by Provider -** If the provider fails to submit the requested data within the aforementioned 60-day timeframe but appears to be making a good-faith effort to do so, the contractor at its discretion may continue processing the application.

- **Incomplete Responses** – The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. Whether the provider indeed furnished all the information is a decision that rests with the contractor. Moreover, if the provider furnishes some, but not all, of the requested data within the 60-day period, the contractor is not required to contact the provider again to request the rest of the information. The contractor has the discretion to wait until the expiration of the 60-day period and then reject the application.

- **Notice of Rejection** – If the contractor rejects the application under this section 3.1, it shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.

- **Documentation** – The contractor shall document in the file the date on which it completed its pre-screening of the application.

- **Commencement of Timeframe** – The 60-day clock described above commences when the contractor mails, faxes, or e-mails the pre-screening letter.

- **Acknowledgment of Receipt** – The contractor may, but is not required to, send out acknowledgment letters.

- **"Not Applicable"** - It is unacceptable for the provider to write "N/A" in response to a question that requires a "yes" or "no" answer. This is considered an incomplete reply, thus warranting the issuance of a pre-screening letter based on missing information.

- **"Pending"** – "Pending" is an acceptable response, requiring no further development, in the following situations:

- **Section 2B2 of the CMS 855** - The license or certification cannot be obtained until after a State survey is performed or RO approval is granted.

- **Section 4 of the CMS 855** - The license/certification cannot be obtained (or the practice location cannot be considered fully established) until after a State survey is performed or RO approval is granted.

- New enrollees who have no Medicare billing number can write "pending" in the applicable "Medicare Identification Number" boxes. (This policy, however, does not apply to NPIs.)

- **Licensure** - For certified suppliers and certified providers, there may be instances where a license may not be obtainable until after the State conducts a survey. Since the license is therefore not "required," the contractor shall not consider this to be "missing" information or documentation.

- **Section 6** – If an authorized or delegated official is not listed in section 6 of the CMS-855, this qualifies as an incomplete application and thus triggers the need for a pre-screening letter.

To summarize, if - during the pre-screening process - the contractor finds that data or documentation is missing, it shall send a pre-screening letter the provider within the 15-day pre-screening period. The provider must furnish all of the missing material within 60 calendar days of the request. If the provider fails to do so, the contractor shall reject the application.

13.1 – *CMS or Contractor Issued Deactivations*

(Rev. 214; Issued: 06-29-07; Effective: 07-02-07; Implementation Date: 07-30-07)

The contractor may deactivate a provider or supplier's Medicare billing privileges when:

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

- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or

- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

The deactivation of Medicare billing privileges does not affect *a supplier's* participation agreement *(CMS-460).*

Deactivation of billing privileges.

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and *must* furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim.

Providers and suppliers *that* fail to promptly notify *the contractor* of a change *(as described above) must submit* a complete Medicare enrollment application to reactivate *their* Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement *or participation agreement.*

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated DPSE contractor liaison within 20 calendar days of the end of each quarter in which deactivations occurred (i.e., January, April, July, and October).

13.2 – Contractor Issued Revocations

(Rev. 214; Issued: 06-29-07; Effective: 07-02-07; Implementation Date: 07-30-07)

The contractor may issue a revocation *(or recommend a revocation)* using revocation reasons 1 through *10 below* without prior approval *from* CMS. *Section 13.3 lists an additional revocation reason that requires DPSE review and approval.*

If a decision is made by *the* contractor to revoke (or recommend a revocation), *the contractor shall* fully and clearly document the reason(s) for the revocation. If there is more than one reason to revoke *the* provider or supplier's Medicare billing privileges, the *contractor shall* describe each reason for revocation in the letter sent to the provider or supplier. *The contractor shall* always support revocation decisions citing the appropriate statute, regulatory or manual instruction. In addition, *the* contractor's revocation letter must contain information regarding *the* provider or supplier's appeal rights.

Revocations issued by a contractor other than the National Supplier Clearinghouse (NSC) become effective within 30 days of the initial revocation notification. Revocations issued by the NSC are effective 15 days after the entity is sent notice of the revocation.

When a provider or supplier number is revoked, *the contractor* must maintain documentation as required *by section 10 of this manual. In addition, when a provider's or supplier's billing privileges are revoked, the provider agreement in effect at the time of revocation is also terminated.*

Prior to issuing a revocation for a Part A provider or a certified Part B supplier, the contractor shall notify DPSE and the applicable regional office's survey and certification unit.

Revocations based on non-compliance:

Revocation 1: The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the applicable enrollment application for its provider or supplier type and has not submitted a plan of corrective action. 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. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement prior to a final determination to revoke billing privileges.

(i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(ii) Requested additional documentation must be submitted within 60 calendar days of request.

The provider, supplier, owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official is excluded from a Federal program (as set forth in either §1862(e)(1) of the Social Security Act (the act); 42 U.S.C. §1395y(e)(1), 42 C.F.R. §1001.1001, §1001.1901 or is/are debarred from participating in a Federal procurement or non-procurement program; (as set forth in §2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. No. 103 55 (1994).

Revocation 2: The provider or supplier has lost its license(s) or is not authorized by the Federal/state/local government to perform the services for which it intends to render. (In the revocation letter or recommendation to revoke, list appropriate citations, e.g., §1861(r) or §1861(s) of the Act.

Revocation 3: The provider or supplier no longer meets CMS regulatory requirements for the specialty for which it has been enrolled. (In the revocation letter, list appropriate regulation.)

Revocation 4: The provider or supplier (upon discovery) does not have a valid SSN/employer identification number for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.

Revocations based on provider or supplier conduct:

Revocation 5: 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 § 1001.2 of this chapter, 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 C.F.R. part 76.

If an excluded party is found, notify DPSE immediately. DPSE will notify the Government Task Leader (GTL) for the appropriate PSC. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

Revocations based on felony:

Revocation 6: The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.

(i) Offenses include—

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

Revocations based on false or misleading information:

Revocation 7: 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 law and regulations.) If it is discovered that the provider or supplier deliberately falsified, misrepresented, or omitted information contained in the application or deliberately altered text on the application form, issue a revocation or recommendation for revocation.

Revocations based on misuse of billing number:

Revocation 8: The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in § 424.80 or a change of ownership as outlined in § 489.18 of this chapter.

Additional revocation reasons:

Revocation 9: CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Revocation 10: 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 to submit an enrollment application and supporting documentation.

13.3.1 - PSC Identified Revocations

(Rev. 214; Issued: 06-29-07; Effective: 07-02-07; Implementation Date: 07-30-07)

If a PSC believes that the use of revocation 11 is appropriate, the PSC will develop a case file, including their reason(s) for revocation, and submit the case file and all supporting documentation to their respective government task leader (GTL) within Division of Benefit Integrity Management Operations (DBIMO). The PSC will provide the GTL with the name, all known billing numbers, including the NPI and associated Medicare billing numbers, and locations of the provider or supplier in question as well as detailed information to substantiate the revocation action.

The GTL will review the PSC case file and:

- *Return the case file to PSC for additional development, or*
- *Recommend that DPSE consider approval the PSC recommendation for revocation.*

If DPSE concurs with GTL's revocation recommendation, DPSE will instruct the applicable fee-for-service contractor to revoke a billing number through a Joint Signature Memorandum and notify the DBIMO of the action taken.

13.3.2 - CMS Satellite Office or Regional Office Identified Revocations

(Rev. 214; Issued: 06-29-07; Effective: 07-02-07; Implementation Date: 07-30-07)

If a CMS satellite office or regional office believes that the use of revocation 11 is appropriate, the CMS satellite office or regional office will develop a case file, including the reason(s) for revocation, and submit the case file and all supporting documentation to DPSE. The CMS satellite office or regional office will provide the DPSE with the name, all known billing numbers, including the National Provider Identifier and associated Medicare billing numbers, and locations of the provider or supplier in question as well as detailed information to substantiate the revocation action.

If DPSE concurs with revocation recommendation, DPSE will instruct the applicable contractor to revoke the billing number and notify DBIMO of the action taken.

Revocation 11: 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 situations where the beneficiary is deceased, the directing physician or beneficiary is not in the state or country when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.