CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 269	**Date: SEPTEMBER 19, 2008**
	Change Request 6178

SUBJECT: Incorporation of Recent Regulatory Revisions into Chapter 10 of the Program Integrity Manual

I. SUMMARY OF CHANGES: This change request recent regulatory revisions involving the following topics: (1) the timeframe in which providers and suppliers must furnish developmental information to the contractor; (2) revocation reason number 11; (3) effective dates of certain types of revocations; (4) Medicare payments during periods when the provider or supplier does not have valid, active billing privileges; (5) corrective action plans; and (6) reapplying for enrollment and revocation.

New / Revised Material
Effective Date: October 20, 2008
Implementation Date: October 20, 2008

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	10/1.1/Definitions
R	10/2/Timeliness and Accuracy Standards
R	10/3.1/Pre-Screening Process
R	10/5.3/Requesting and Receiving Clarifying Information
R	10/6.2/Denials
R	10/8/Electronic Fund Transfers (EFT)
R	10/13.2/Contractor Issued Revocations
R	10/13.3.2/CMS Satellite Office or Regional Office Identified Revocations

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 269	Date: September 19, 2008	Change Request: 6178

SUBJECT: Incorporation of Recent Regulatory Revisions into Chapter 10 of the Program Integrity Manual

Effective Date: October 20, 2008
Implementation Date: October 20, 2008

I. GENERAL INFORMATION

A. Background: This change request incorporates recent regulatory revisions involving the following topics: (1) the timeframe in which providers and suppliers must furnish developmental information to the contractor; (2) revocation reason number 11; (3) effective dates of certain types of revocations; (4) Medicare payments during periods when the provider or supplier does not have valid, active billing privileges; (5) corrective action plans (CAPs); and (6) reapplying for enrollment after a revocation.

B. Policy: The purpose of this change request is to incorporate recent regulatory changes into chapter 10.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6178.1	The contractor shall adhere to the timeliness and accuracy standards in sections 2.1 through 2.3 of chapter 10, notwithstanding the provisions of 42 CFR §405.874(h).	X		X	X	X					
6178.2	The contractor shall note that in accordance with 42 CFR §424.525(a)(1), it may reject the provider's or supplier's CMS-855 application if the provider or supplier fails to furnish complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information.	X		X	X	X					
6178.3	In cases where the provider or supplier is required to submit a new CMS-588 form pursuant to a change in Medicare contractors, the new contractor shall process the CMS-588 in the same manner as it would in any other situation.	X		X	X	X					
6178.4	The contractor shall note that Revocation Reason 11 has been codified in 42 CFR §424.535(a)(8).	X		X	X	X					
6178.5	The contractor shall note that per 42 CFR §405.874(b)(2), a revocation is effective 30 days after	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the contractor mails the notice of its determination to the provider or supplier.										
6178.6	The contractor shall note that per 42 CFR §405.874(b)(2), a revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment.	X		X	X	X					
6178.7	The contractor shall note that a revocation based on the revocation or suspension of the provider's or supplier's license or certification to perform services can be made retroactive to the date of the license suspension/revocation.	X		X	X	X					
6178.8	Per 42 CFR §405.874(b)(3), the contractor shall reject claims for items or services submitted with a service date on or after the effective date of the provider's or supplier's revocation.	X		X	X	X					
6178.9	Per 42 CFR §405.874(e), if a provider or supplier completes a CAP and provides sufficient evidence to the contractor that it has complied fully with the Medicare requirements, the contractor shall have the option to reinstate the provider's or supplier's billing privileges. (The contractor may pay for services furnished on or after the effective date of the reinstatement; the effective date is based on the date the provider or supplier is in compliance with all Medicare requirements.)	X		X	X	X					
6178.10	Prior to sending out a revocation letter, the contractor shall refer the matter to the Division of Provider and Supplier Enrollment (DPSE), which will make the determination as to the appropriate length of the re-enrollment bar under 42 CFR §424.535(c).	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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6178.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your 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.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Carriers (RHHIs):* No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*: The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

1.1 – Definitions

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

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

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 a company that the applicant contracts with to prepare, edit and/or submit claims on its behalf.

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.

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 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 for Medicare covered items or services provided to Medicare beneficiaries.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes:

- Identification of a provider or supplier;

- Validation of the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;

- Identification and confirmation of the provider or supplier's practice locations and owners; and

- Granting the provider or supplier Medicare billing privileges.

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

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 is the generic term for any number, other than the National Provider Identifier, used by a provider or supplier to bill the Medicare program.

(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.)

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 means 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.

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 or non-physician practitioner, except physician assistants, has granted a clinic or group practice the right to receive payment for the practitioner's services.

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)) the individual or organization uses to report tax information to the IRS.

2 – Timeliness and Accuracy Standards

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

Sections 2.1 through 2.3 of this *chapter* address the timeliness and accuracy standards applicable to the processing of CMS-855 applications. *Even though the provisions of 42 CFR §405.874(h) contain processing timeframes that are longer than those in sections 2.1 through 2.3, the contractor shall adhere to the standards specified in sections 2.1 through section 2.3.*

3.1 – Pre-Screening Process

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

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 <u>only</u> 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 *chapter* 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*)(1) and (2), respectively*, the contractor may reject the provider's application if the provider fails to furnish *complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information or documentation.*

The *30*-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 *30*-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. To illustrate, suppose *that* the contractor sent out a pre-screening letter on March 1 (thus triggering the *30*-day clock) *that asked for clarifying information in Sections 4 and 5 of the CMS-855B*. *(All supporting documentation was provided.)* 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 *20* to request the *remaining* missing data. The provider failed to respond. The contractor can reject the application on *March 31*, which is *30* days after the initial request.

NOTE: *The* contractor has the discretion to extend *the 30*-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 *30*-day period, this does not stop or restart the *30*-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 section 2.3 of this *chapter*. 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.

- **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 applicable time 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 applicable timeframe* 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 *30*-day clock identified in *42 CFR §424.525(a)* 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.

  - ***Medicare Identification Number*** - 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 *to* the provider within the 15-day pre-screening period. The provider must furnish all of the missing material *or documentation within the applicable timeframe.* If the provider fails to do so, the contractor *may* reject the application.

5.3 – Requesting and Receiving Clarifying Information

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

A. Requesting Clarifying Data

After the completion of *the pre*-screening phase, if the contractor determines that it needs clarifying information from the provider, the contractor shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the elements listed below:

1. A list of all data to be clarified *and documentation to be submitted*;

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

3. The name and phone number of a contact person at the contractor site;

4. The CMS Web site at which the CMS-855 forms can be found. The contractor shall instruct the provider to: (1) print out the page(s) containing the data in question; (2) enter the data on the blank page; (3) sign and date a new, blank certification statement; and (4) 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.

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

(The contractor can forgo items 4 and 5 above if resolution of the issue will not involve changes to the CMS-855.)

If the provider fails to furnish all of the requested clarifications *and documentation within the timeframes specified in 42 CFR §424.525(a) and section 3.1 of this chapter,* the contractor *may* reject the application. 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 the rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.

In addition:

- **Only One Request Needed** - The "clarification letter" is the only request for clarification that the contractor must make. Obviously, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the clarification letter. However, the contractor need not – on its own volition – make an additional request for clarification *unless it uncovers missing information that it failed to previously spot.*

  To the maximum extent possible, the contractor should avoid contacting a provider for clarifying information until it has attempted to verify all of the data on the application. This will obviate the need to contact the provider each time the contractor discovers a discrepancy.

- **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 enunciated in this section 5.3 apply to all CMS-855 applications identified in sections 2.1 and 2.2 of this *chapter* (e.g., changes of information, reassignments).

- **Good-Faith Effort by Provider** – If the provider fails to submit the requested clarification within *the timeframes specified in 42 CFR §424.525(a) and section 3.1 of this chapter* but appears to be making a good-faith effort to do so, the contractor may at its discretion continue processing the application.

- **Incomplete Responses** – The provider must furnish <u>all</u> clarifying data requested by the contractor within the applicable timeframe*s*. Whether the provider indeed furnished all the information is a decision resting solely with the contractor.

  Moreover, if the provider furnishes some, but not all, of the requested data within the *applicable time period*, the contractor is not required to contact the provider again to request the rest of the information. *For instance, suppose the contractor requested clarification of certain items in Sections 3, 4 and 5 of the CMS-855A. Clarification was only furnished with respect to the Section 3 information.* The contractor has the discretion to wait until the expiration of the *30*-day period and then reject the application; however, as stated above, it should take into account any good-faith efforts of the provider to furnish the information.

- **Rejections vs. Denials** – If the provider failed to fully comply with the contractor's request for additional or clarifying information, there are two possible outcomes:

  - Rejection of the application under 42 CFR § 424.525(a), due to the provider's failure to furnish *the missing data or documentation,* or

  - Denial of the application if one of the denial reasons in section 6.2 of this *chapter* is implicated.

  If the contractor is faced with this situation, it is free to contact its DPSE contractor liaison for guidance prior to making its decision to reject or deny.

- **Commencement of Timeframe** – *For information requests under 42 CFR §424.525(a)(1), the 30*-day clock described above commences when the contractor mails, faxes, or e-mails the letter.

B. Relationship to the Pre-Screening Process

The contractor may begin the verification process during the pre-screening phase described in section 3.1 of this *chapter*. If the contractor, in doing so, uncovers data requiring further development (e.g., problems verifying the SSN of a managing employee; Qualifier.net indicates that a person may be using two SSNs), the contractor may include this request for clarifying information within the pre-screening letter. This,

in turn, means that the provider must furnish: (1) all *missing* data and documentation requested in the pre-screening letter *within the applicable timeframe specified in 42 CFR §424.525(a),* and (2) all clarifications asked for in the contractor's request for clarifying information *within the applicable timeframe specified in 42 CFR § 424.525(a).*

EXAMPLE 1: The provider submits a CMS-855B on March 1. The contractor pre-screens the application and finds that all data elements have been completed and all required documentation submitted. Hence, no pre-screening letter is needed. Since several SSN discrepancies were found during the validation process, however, the contractor sent a request for clarifying information to the provider on March 20. In this scenario, the provider must furnish all of the requested data/clarifications by *April 19.*

EXAMPLE 2: The provider submits a CMS-855B on March 1. The contractor completed its pre-screening of the application on March 7 and found that three relatively minor data elements were missing, thus triggering the need for a pre-screening letter to be sent no later than March 16. The contractor decides to begin the verification process on March 8 and completes validation on March 13, finding two SSN discrepancies. The contractor thus sends out a single letter on March 14 addressing both the missing data elements (pre-screening) and the SSN issues (request for clarifying information). In this situation, the provider must furnish both the missing data elements and the requested clarification by *April* 13.

Now suppose that the contractor had not completed the entire verification process by March 16. In its pre-screening letter, the contractor identified the missing information and requested clarification of the two SSN discrepancies. The contractor completed the validation process on April 2; that same day, the contractor sent a request for additional information to the provider regarding two EIN discrepancies. In this scenario, the provider must furnish the missing information and SSN clarifications by *April 13.* Even if it does so, it must still provide the EIN clarifications by *May* 1 (or *30* days after the April 2 letter was sent). If the provider fails to comply with the March 14 letter, the contractor may reject the application on *April* 13 without waiting to see if the provider can furnish the requested EIN clarifications.

C. Receiving Clarifying Information

Unless stated otherwise in this manual, any data collected on the CMS-855 for which the contractor requested clarification must be furnished by the provider on the applicable page(s) of the CMS-855. A newly-signed and dated certification statement must also be submitted. Note that this certification statement must be separate and distinct from the previous certification statement; that is, the provider cannot simply add its signature to the existing statement. It must sign a separate one.

The contractor can receive the clarifying information, including the new certification statement, via fax. Upon receipt, the contractor shall verify the new data. (The contractor need not re-verify the existing data on the application.)

D. Unsolicited Submission of Clarifying Information

Any new or changed information submitted by an applicant prior to the date the contractor finishes processing the application is considered to be an update to the original application. (It is immaterial whether the data was requested by the contractor.) The data is not considered to be a separate change of information. For instance, suppose the provider submitted an initial enrollment application to the fiscal intermediary. On the 58th day – one day before the intermediary planned to make its recommendation for approval – the provider on its own volition submitted updates to its section 6 data. The intermediary must process this information prior to making its recommendation, even if it takes the application beyond the *30*-day limit. The contractor cannot make its recommendation as planned on the 59th day and simply process the section 6 data as a change of information after the fact. Of course, if the late-arriving data takes the timeframe over 60 days, the contractor should document the file and explain the special circumstances involved.

E. Site Visits

In addition to the site visits required for all IDTF, DME and CMHC applicants (which have their own site visit instructions), the contractor may conduct site visits: (1) of other applicants seeking enrollment in the Medicare program, or (2) to verify the status of currently enrolled providers. Such site visits should be unannounced; the contractor representatives shall always conduct themselves in a professional manner, disclosing to the provider appropriate identifying credentials and explaining the purpose of the visit. The contractor shall maintain records of all site visits to support decisions regarding the denial or revocation of a Medicare billing number.

6.2 – Denials

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

A. Denial Reasons

Per 42 CFR §424.530(a), contractors must deny an enrollment application if any of the situations described below are present, and must provide appeal rights.

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 10 as the basis for denial.

Note that 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/RO. The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider in a format similar to that which is used for carrier denials of non-certified supplier applications (see sections 14 and 19 of this *chapter*). The contractor shall copy the State and the RO on said letter.

Denial Reason 1 (42 CFR §424.530(a)(1))

The provider or supplier is determined not to be in compliance with the Medicare enrollment requirements described in this section or on the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in *42CFR* part 488.

Denial Reason 2 (42 CFR §424.530(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier 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 nonprocurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

Denial Reason 3 (42 CFR §424.530(a)(3))

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

- Felony crimes against persons, 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.

Denial Reason 4 (42 CFR §424.530(a)(4))

The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program. (The contractor shall contact its

DPSE contractor liaison prior to issuing or recommending denial of an application on this ground.)

Denial Reason 5 (42 CFR §424.530(a)(5))

The CMS determines, upon onsite review or other reliable evidence, that the provider or supplier is not operational to furnish Medicare covered items or services, or does not meet Medicare enrollment requirements to furnish Medicare covered items or services. This includes, but is not limited to, the following situations:

- The applicant does not have a license(s) or is not authorized by the Federal/State/local government to perform the services for which it intends to render. (In its denial letter, the contractor shall cite the appropriate statute and/or regulations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this *chapter*. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with.)

- The applicant does not have 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 (as set forth in §1833(e) of the Social Security Act.)

- The applicant does not meet CMS regulatory requirements for the specialty. (In its denial letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this *chapter*. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with.)

- The applicant does not qualify as a provider of services or a supplier of medical and health services. 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)).

NOTE: This denial provision should be used in cases where the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors).

- The applicant does not provide a valid SSN/EIN for the applicant, owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.

- A home health agency (HHA) does not meet the capitalization requirements outlined in 42 CFR §489.28.

B. Denial Letters

When a decision to deny is made, the carrier shall send a letter to the supplier by *certified mail* identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of that shown in section 14 of this *chapter.*

As previously indicated, *and in accordance with 42 CFR § 405.874*(a), all denial (or recommendation for denial) letters *shall* contain sufficient factual and background information so that the reader understands exactly why the denial occurred. It is not enough to simply list one of the denial reasons. All applicable regulations, as well as a detailed factual rationale for the contractor's decision, must be identified in the letter. For instance, if an application is denied based on falsification, the carrier must identify in its letter the falsified information, how and why the carrier determined it was false, the regulation in question, etc. If there were multiple reasons for denial, the letter shall state as such and shall furnish all of the aforementioned statutes, regulations, facts, etc. applicable to each reason. *The notice must also identify the provider's right to appeal under 42 CFR Part 498 and the address to which the written appeal must be mailed.* For more detailed information on the appropriate composition of denial letters, see *sections 14 and 19* of this *chapter*.

C. Post-Denial Submission of Enrollment Application

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

- If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.

- If the denial was appealed, the provider or supplier may reapply after it 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 (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, 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. The contractor, however:

- Need not solicit or ask for such proof in its denial letter. It is up to the provider to furnish this data on its own volition.

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

See section 19 of this *chapter* for information on Corrective Active Plans (CAP).

8 – Electronic Fund Transfers (EFT)

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

If a provider does not have an established enrollment record in PECOS and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete CMS-855 form before the contractor can effectuate the change. It is immaterial whether: (1) the provider or the bank (e.g., change in bank name via merger) was responsible for triggering the changed data or (2) the signer of the CMS-588 already has a signature on file with the contractor. (For more information on how the contractor should handle this type of situation, see sections 7.1.1 and 7.1.2 of this *chapter*.)

As stated in 42 CFR §424.510(d)(2)(iv) and §424.510(e), all providers (including Federal, State and local governments) entering the Medicare program for the first time must use EFT in order to receive payments. Moreover, any provider not currently on EFT that: (1) submits any change to its existing enrollment data or (2) submits a revalidation application, must also submit a CMS-588 form and thereafter receive payments via EFT.

Under 42 CFR §424.510(d)(2)(iv) and §424.510(e), if a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors (e.g., fiscal intermediary to an A/B MAC), the provider must continue to receive EFT payments and, to this end, must also submit a new CMS-588 form that authorizes the new contractor to make payments to the provider's EFT account. The contractor shall process the CMS-588 in this situation as it would in any other scenario.

In addition:

- ***Banking Institutions*** - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

  If the provider's bank of choice does not or will not participate in the provider's proposed EFT transaction, the provider must select another financial institution.

- **Verification** - The contractor shall verify that all initial EFT applications and EFT changes comply with Pub. 100-04, chapter 1, section 30.2.5.

- **Sent to the Wrong Unit** - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is ultimately responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's CMS-855 in the file.

- **CMS 588 Changes and PECOS –** In situations where the only data the provider is changing is on the CMS-588 (i.e., no data is changing on the CMS-855), the contractor shall process the EFT change using the timeframes cited in section 2.2 of this *chapter*; moreover, and notwithstanding any instruction to the contrary in this manual, the contractor shall create an L & T record using the "Other" button in PECOS.

- **Comparing Signatures** - If the contractor receives an EFT change request, it shall compare the signature thereon with the same official's signature on file to ensure that it is indeed the same person. (See also Pub. 100-04, chapter 24, section 40.7) If the person's signature is not already on file, the contractor shall request that he/she complete section 6 of the CMS-855 and furnish his/her signature in section 15 or 16 of the CMS-855. (This shall be treated as part of the EFT change request for purposes of timeliness and reporting.)

- **Bankruptcies and Garnishments** – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel. (In general, all court orders take precedence over the instructions in this *chapter*.)

- **Closure of Bank Account** – There may be situations where a provider has closed its bank/EFT account but will remain enrolled in Medicare. The contractor shall place the provider on payment withhold until an EFT agreement (and CMS-855, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor first learned that the account was closed, the contractor shall commence revocation procedures in accordance with the instructions in this *chapter*.

- **Reassignments** – If a physician or practitioner is reassigning all of his/her benefits to another supplier, neither the practitioner nor the group needs to submit a CMS-588 form. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. Of course, if the group later submits a change of information request (e.g., adding a new owner in section 6) and is not currently on EFT, it must submit a CMS-588.

- **Final Payments** - In situations where a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send said payments to the provider's EFT

account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the addresses discussed above are in existence, the provider shall submit a CMS-855 or CMS-588 request identifying where it wants payments to be sent.

- **Chain Organizations -** Per Pub. 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate CMS 588s must be submitted. If any of the chain providers have never completed a CMS-855 before, they must do so at that time.

- ***Audit and Claims Intermediaries –*** *In cases where the provider's audit and claims intermediaries differ, the contractor shall not reject the provider's CMS-588 form if the provider listed the claims intermediary – rather than the audit intermediary – thereon.*

13.2 – Contractor Issued Revocations

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

A. Revocation Reasons

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.

When issuing a revocation, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter 10 as the basis for revocation.

Revocations based on non-compliance:

Revocation 1 (42 CFR §424.535(a)(1))

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR Part 488.

Noncompliance includes, but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider

or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements.

Revocation 2

The provider or supplier has lost its license(s) or is not authorized by the Federal/state/local government to perform the services for which it intends to render. (In its revocation letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this *chapter*. Note that the contractor must identify in the revocation letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with.)

Revocation 3

The provider or supplier no longer meets CMS regulatory requirements for the specialty for which it has been enrolled. (In its revocation letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this *chapter*. Note that the contractor must identify in the revocation letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with.)

Revocation 4 (42 CFR §424.535(a)(1))

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

Revocations based on provider or supplier conduct:

Revocation 5 (42 CFR §424.535(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in *42CFR* §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 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 (42 CFR §424.535(a)(2))

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

(i) Offenses include—

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

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

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

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

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

Revocations based on false or misleading information:

Revocation 7 (42 CFR §424.535(a)(4))

The provider or supplier certified as ‘‘true’’ misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current 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 (42 CFR §424.535(a)(7))

The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in *42CFR* §424.80 or a change of ownership as outlined in *42CFR* §489.18.

Additional revocation reasons:

Revocation 9 (42 CFR §424.535(a)(5))

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

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

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

Revocation 10 (42 CFR §424.535(a)(6))

The provider or supplier fails to furnish complete and accurate information and all supporting documentation within *30* calendar days of the provider or supplier's notification from CMS to submit an enrollment application and supporting documentation.

B. Revocation Letters

I*n accordance with 42 CFR § 405.874(b),* all revocation letters *shall be sent by certified mail and shall* contain sufficient factual and background information so that the reader understands exactly why the revocation occurred. It is not enough to simply list one of the revocation reasons. All applicable regulations, as well as a detailed factual rationale for the contractor's decision, must be identified in the letter. For instance, if a provider is revoked based on the submission of false information, the *contractor* must identify in its letter the falsified information, how and why the *contractor* determined it was false, the regulation in question, etc. If there were multiple reasons for revocation, the letter shall

state as such and shall furnish all of the aforementioned statutes, regulations, facts, etc. applicable to each reason. *The notice must also identify the provider's right to appeal under 42 CFR Part 498 and the address to which the written appeal must be mailed.* For more detailed information on the appropriate composition of revocation letters, see *sections 14 and 19* of this *chapter*.

When a provider or supplier number is revoked, the contractor must maintain documentation as required by section 10 of this *chapter*. 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.*

C. Effective Date of Revocations

Per 42 CFR §405.874(b)(2), a revocation is effective 30 days after CMS or the CMS contractor mails the notice of its determination to the provider or supplier. However, a revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment. In addition, if the revocation was due to the revocation or suspension of the provider/supplier's license or certification to perform Medicare services, said revocation can be made retroactive to the date of the license suspension/revocation.

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, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its recommendation letter. It is up to the provider to furnish this data on its own volition.

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

D. Payment

Per 42 CFR §405.874(b)(3),Medicare does not pay and a CMS contractor rejects claims for items or services submitted with a service date on or after the effective date of a provider's or supplier's revocation.

E. Corrective Action

Per 42 CFR §405.874(e), if a provider or supplier completes a corrective action plan and provides sufficient evidence to the contractor that it has complied fully with the Medicare requirements, the contractor may reinstate the provider's or supplier's billing privileges. The contractor may pay for services furnished on or after the effective date of the reinstatement. The effective date is based on the date the provider or supplier is in compliance with all Medicare requirements.

A contractor's refusal to reinstate the provider or supplier's billing privileges based on a corrective action plan is not an initial determination under 42CFR part 498.

F. Reapplying After Revocation

As stated in 42 CFR §424.535(c), after a provider, supplier, delegated official, or authorizing official that has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation. For instance, a revocation on the grounds that the provider is no longer operational will generally warrant a 2 year bar; a revocation based on a felony conviction or the submission of false information will typically result in a 3 year bar.

Prior to sending out the revocation letter, the contractor shall refer the matter to DPSE, which will make the determination as to the appropriate length of the re-enrollment bar.

13.3.2 - CMS Satellite Office or Regional Office Identified Revocations

(Rev. 269: Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

If a CMS satellite office or regional office believes that the use of revocation 11 (see *42 CFR §424.535(a)(8) and section 13.2 of this chapter)* 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 *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.

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 *(42 CFR §424.535(a)(8))*

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 services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.