CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 412	**Date: March 30, 2012**
	Change Request 7646

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part II

I. SUMMARY OF CHANGES: This change request (CR) is the second in a series of transmittals designed to update chapter 15 of the PIM. The revisions in this CR: (1) are editorial in nature, or (2) incorporate existing policies directly into chapter 15.

EFFECTIVE DATE: April 30, 2012
IMPLEMENTATION DATE: April 30, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/15.1.2/Medicare Enrollment Application (Form CMS-855)
D	15/15.7.5.2/Verification of Legalized Status
R	15/15.8.4/Denials
R	15/15.19.1/Application Fees
R	15/15.20.2/Reserved for Future Use
D	15/15.21.9/Compliance Standards for Enrollment of Mail Order Pharmacies and Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Delivered Through Other Than the Supplier's Location or Beneficiary Address
R	15/27.1/CMS or Contractor Issued Deactivations
R	15/27.2/Revocations
R	15/27.2.1/Special Instructions Regarding Revocations of Certified Suppliers and Providers
D	15/15.34.3/Mailing Annual "Supplier Responsibilities" Letter
D	15/15.34.3.1/Mailing Annual Material to Physicians
D	15/15.34.3.2/Mailing Annual Material to Non-physician Sole Practitioners
D	15/15.34.3.3/Mailing Annual Material to Physicians and Non-physician Practitioner Organizations

III. FUNDING:

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

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: 412	Date: March 30, 2012	Change Request: 7646

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part II

Effective Date: **April 30, 2012**
Implementation Date: April 30, 2012

I. GENERAL INFORMATION

A. Background: This change request (CR) is the second in a series of transmittals designed to update chapter 15 of the PIM. The revisions in this CR: (1) are editorial in nature, or (2) incorporate existing policies directly into chapter 15.

B. Policy: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

II. BUSINESS REQUIREMENTS 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	
7646.1	**NOTE:** The contractor shall view the reorganization of the denial and revocation reasons in, respectively, sections 15.8.4 and 15.27.2 of chapter 15.	X		X	X	X					National Supplier Clearinghouse (NSC)

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	
	None										

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

V. CONTACTS

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

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

Section B: *For Medicare Administrative Contractors (MACs)*:

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

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents

(Rev.412, Issued: 03-30-12)

15.1.2 – Medicare Enrollment Application (*Form* CMS-855)

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

Providers and suppliers, including physicians, may enroll or update their Medicare enrollment record using the:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- Paper enrollment application process (e.g., *Form* CMS-855I).

The Medicare enrollment applications are issued by CMS and approved by the *Office of Management and Budget.*

*T*he five *enrollment applications* are distinguished as follows:

- CMS-855I - This *application should* be completed by *physicians* and non-physician *practitioners who* render Medicare Part B services *to beneficiaries*. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity*.)*

- CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The *individual* must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

- CMS-855B - This application should be completed *by s*upplier organization*s* (e.g., ambulance compan*ies*) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

- CMS-855A - This application should be completed by institutional providers (e.g., hospital*s*) that will furnish Medicare Part A services *to b*eneficiaries.

- CMS-855S – This application should be completed *by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)*. The *National Supplier Clearinghouse (NSC)* is responsible for processing this type of enrollment application.

A separate application must be submitted for each provider/supplier type.

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment *Form* CMS-85*5,* the contractor shall *encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:*

- The CMS Web site *at which information on Internet-based PECOS can be found and at which the* paper applications can be accessed (www.cms.hhs.gov/MedicareProviderSupEnroll).

- *A*ny supporting documentation required for the applicant's provider/supplier type.

- *Other required forms, including:*

  - The Electronic Funds Transfer Authorization Agreement (*Form* CMS-588) (Note: The NSC is only required to collect the *Form* CMS-588 with initial enrollment applications.)

  - The Electronic Data *Interchange agreement* (Note: This does not apply to the NSC.)

  - The Medicare Participating Physician or Supplier Agreement (*Form* CMS-460). *The contractor shall explain to the provider or supplier* the purpose of the agreement and how it differs from the actual enrollment process. *(This only applies to suppliers that complete the Forms CMS-855B and CMS-855I.)*

- The contractor's address *so* that the applicant knows where to return the completed application.

- If the applicant is a certified supplier *or certified* provider*, the need to c*ontact the State agency for any *S*tate-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities*, such as federally qualified health centers,* that do not receive a State survey.) The notification can be given in any manner the contractor chooses.

15.8.4 – Denials

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

A. Denial Reasons

Per 42 CFR §424.530(a), *the* contracto*r* 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 *15* as the basis for denial.

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

contractor shall copy the State and the RO on said letter.

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

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 42 CFR part 488. Such non-compliance includes, but is not limited to, the following situations:

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

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

c. The provider or supplier is not appropriately licensed.

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

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as.

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

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

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

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter. Note that the contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

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

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- Excluded from Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or

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

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

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.

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

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact its Provider Enrollment Operations Group (PEOG) liaison for assistance.

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 *PEOG liaison* prior to *denying an* application on this ground*.)*

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

CMS or its contractor(s) determines, upon on-site review or other reliable evidence, that the provider or supplier is not operational or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is not 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 not 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.

Denial Reason 6 (42 CFR §424.530(a)(6))

The current owner (as defined in §424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Denial Reason 7 (42 CFR §424.530(a)(7))

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

Denial Reason 8 (42 CFR §424.530(a)(8))

A home health agency (HHA) submitting an initial application for enrollment:

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

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

Denial Reason 9 (42 CFR §424.530(a)(9))

The institutional provider's (as that term is defined in 42 CFR §424.502) hardship exception request is not granted, and the institutional provider does not submit the

required application fee within 30 days of notification that the hardship exception request was not approved.

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

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

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

Denial Reason 10 (42 CFR §424.530(a)(10))

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

B. Denial Letters

When a decision to deny is made, the *contractor* shall send a letter to the *provider* identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of *those* shown in section *15.24 et seq.* of this chapter.

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

C. Post-Denial Submission of Enrollment Application

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

- If the denial was not appealed, the provider or *supplier's appeal* rights have lapsed*, or*

- If the denial was appealed, the provider or *supplier has* received notification that the determination was upheld.

D. 30-Day Effective Date of Denial

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

As stated in 42 CFR §424.530(c), if the denial was due to adverse activity (*e.g., exclusion, felony*) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider

or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

E. Provider Enrollment Appeals Process

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

15.19.1 – Application Fees

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

A. Background

Pursuant to 42 CFR §424.514 - and with the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR §424.515, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that the contractor receives on or after March 25, 2011.

For purposes of this requirement, the term "institutional provider," as defined in 42 CFR §424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS- 855B (not including physician and non-physician practitioner organizations), Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011 through December 31, 2011 is $505.00. *The fee for January 1, 2012 through December 31, 2012 is $523.00.* Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the

prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

Per 42 CFR §424.514(d)(2)(v), the application fee is non-refundable, except if it was submitted with one of the following:

a. A hardship exception request that is subsequently approved;

b. An application that was rejected prior to the contractor's initiation of the screening process, or

c. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR §424.570.

(For purposes of (B)(2)(b) above, the term "rejected" includes applications that are returned pursuant to section 15.8.1 of this Chapter.)

In addition, the fee should be refunded if:

- It was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number).

- It was not part of an application submission.

3. Format

The provider or supplier must submit the application fee electronically through Pay.gov, either via credit card, debit card, or check. Note that CMS will send to the contractor on a regular basis a listing of providers and suppliers (the "Fee Submitter List") that have paid an application fee via Pay.gov.

The contractor shall also note with respect to the application fee requirement:

- *The fee is based on the Form CMS-855 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.*

- *A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is: (1) Tribally-owned/operated, or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is*

required because the hospital is adding a practice location.

C. Hardship Exception

1. Background

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters shall not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider, and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

The application fee for Calendar Year *2012* is *$523* and generally should not represent a significant burden for an adequately capitalized provider or supplier. Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

(a) Considerable bad debt expenses,

(b) Significant amount of charity care/financial assistance furnished to patients,

(c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

(d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

(e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its Provider Enrollment Operations Group (PEOG) liaison. PEOG has 60 calendar days from the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. PEOG will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 19.1(D) below.

Note that if the provider fails to submit appropriate documentation to support its request, the contractor is not required to contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG liaison. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

D. Receipt

Upon receipt of a paper application (or, if the application is submitted via Internet-based PECOS, upon receipt of a certification statement) from a provider or supplier that is otherwise required to submit an application fee, the contractor shall first determine whether the application is an initial enrollment, a revalidation, or involves the addition of a practice location. If the application does not fall within any of these categories, the contractor shall process the application as normal. If it does fall within one of these categories, the contractor shall undertake the following:

a. Determine whether the provider has: (1) paid the application fee via Pay.gov, and/or (2) included a hardship exception request with the application or certification statement. The contractor can verify payment of the application fee by checking:

- Whether the provider has included with its application or certification statement a Pay.gov receipt as proof of payment, and/or

- The Fee Submitter List

b. If the provider:

i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original

application, CMS will not consider granting a hardship exception in lieu of the fee.

During this 30-day period, the contractor shall review each updated Fee Submitter List to determine whether the fee has been paid via Pay.gov. If the fee is paid within the 30-day period, the contractor may begin processing the application as normal. If the fee is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR §424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

Note that if, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.

ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.

iii. Has submitted a hardship exception request but has not paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG liaison. If PEOG:

a. Denies the hardship exception request, it will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall review each updated Fee Submitter List to determine if the fee has been submitted via Pay.gov. If the fee is not paid within 30 calendar days, the contractor shall deny the application (initial enrollments and new locations) pursuant to 42 CFR §424.530(a)(9) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.

b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied). The contractor shall begin processing the application as normal.

iv. Has submitted a hardship exception request and has paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG liaison. As the fee has been paid, the contractor shall begin processing the application as normal.

In all cases, the contractor shall not begin processing the provider's application until:

(1) the fee has been paid, or (2) the hardship exception request has been approved.

E. Appeals of Hardship Determinations

A provider may appeal PEOG's denial of its hardship exception request via the procedures outlined below:

1. If the provider is dissatisfied with PEOG's decision to deny a hardship exception request, it may file a written reconsideration request with PEOG within 60 calendar days from receipt of the notice of initial determination (e.g., PEOG's denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

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

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post-hardship exception request instructions in subsections (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

PEOG has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be:

(a) Conducted by a PEOG staff person who was independent from the initial decision to deny the hardship exception request.

(b) Based on PEOG's review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, PEOG will send a letter to the provider or supplier to acknowledge receipt of its request. In its acknowledgment letter, PEOG will advise the requesting party that the reconsideration will be conducted and a determination issued within 60 days from the date of the request.

If PEOG denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If PEOG approves the reconsideration request, it will notify the provider of this via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable:

i. If the application has already been rejected, request that the provider resubmit the application without the fee, or

ii. If Medicare billing privileges have already been revoked, reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

Note that Corrective Action Plans (CAPs) may not be submitted in lieu of or in addition to a request for reconsideration of a hardship exception request denial.

2. If the provider is dissatisfied with the reconsideration determination regarding the application fee, it may request a hearing before an Administrative Law Judge (ALJ). Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

Department of Health and Human Services
Departmental Appeals Board (DAB)
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Bldg, Room G-644
Washington, D.C. 20201
ATTN: CMS Enrollment Appeal

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request, and the application has already been rejected, the contractor – once PEOG informs it of the ALJ's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

If the DAB reverses the ALJ's decision and approves the hardship exception request, and the application has already been rejected, the contractor - once PEOG informs it of the DAB's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the

application without the fee.

To the extent permitted by law, a provider or supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such request shall be filed within 60 days from receipt of the notice of the DAB's decision.

F. Miscellaneous

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non-physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application.

3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:

    - Reporting a change of ownership via the Form CMS-855B or Form CMS-855S. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

    - Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS)

    - Requesting a reactivation of the provider's Medicare billing privileges

- *Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).*

Note that the application fee requirement is separate and distinct from the site visit requirement and risk categories discussed below. Physicians, non-physician practitioners, physician groups and non-physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per section 15.19.2.5 of this chapter. Similarly, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

4. *Non-Payment of the Fee - If the application is rejected or denied due to non-payment of the fee, the contractor shall:*

- *Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.*

- *Indicate in PECOS that a developmental request was made.*

- *Switch the enrollment record to a "denied" or "rejected" status, as applicable per section 19.1(D).*

- *Notify the applicant of the rejection or denial in accordance with section 19.1(D).*

15.20.2 – *Reserved for Future Use*

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

15.27.1 – CMS or Contractor Issued Deactivations

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

A. General Instructions

Unless indicated otherwise in this chapter or in another CMS instruction or directive, 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).

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.

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. However, per 42 CFR §424.540(b)(3)(i), and as described in subsection E below, an HHA whose billing privileges are deactivated must undergo a State survey or obtain accreditation prior to having its billing privileges reactivated.

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated DPSE contractor liaison no later than the last calendar day of each month.

B. Special Reactivation Instructions for Part B Suppliers

(This section *27.1(B)* does not apply to: (1) providers and suppliers that complete the CMS-855A application, and (2) *suppliers of durable medical equipment, prosthetics, orthotics and suppliers (DMEPOS)).*

To ensure that a supplier that has reactivated its Medicare billing privileges does not become subject to a second deactivation for non-billing within 30 days of the reactivation, the contractor shall:

1. End-date the existing *Provider Transaction Access Number (PTAN)-National Provider Identifier (NPI)* combination in sections 1 and 4 of *the Provider Enrollment, Chain and Ownership System (PECOS)* with the non-billing end-date in MCS, and

2. Issue a new Provider Transaction Access Number (PTAN) to the provider or supplier, and associate the new PTAN with the NPI in sections 1 and 4 of PECOS.

For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, or organizations

(e.g., group practices) consisting of any of the aforementioned categories of individuals, the contractor shall establish the reactivation effective date as the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location.

The exception to this is if the supplier has at least one other enrolled practice location (under the same TIN) for which it is actively billing Medicare; here, the contractor shall establish and enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later. To illustrate, if the supplier has only one enrolled practice location and that site is deactivated for non-billing, the effective date is the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location. On the other hand, suppose the supplier has two enrolled locations – X and Y - under its TIN. Location X is actively billing Medicare, but Y is deactivated for non-billing. The reactivation effective date for Y would be the later of: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS. This is because the supplier has at least one other location – Location X – that is actively billing Medicare.

For individual and organizational suppliers other than those identified in the beginning of the previous paragraph, the contractor shall enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later.

If the supplier's PTAN is only established in MCS, no action is required if the end-dated non-billing number is not in PECOS.

C. DMEPOS Deactivation

The *National Supplier Clearinghouse (NSC)* shall require a DMEPOS supplier whose billing privileges are deactivated for non-submission of claims (see CFR 42 CFR §424.540) to submit a new Medicare enrollment application and meet all applicable enrollment criteria, including a site visit, and accreditation when applicable, before an applicant can be approved. The NSC may not establish a retrospective billing date for a DMEPOS supplier whose billing privileges were deactivated due to claims inactivity.

D. Deactivation and Appeals Rights

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is *made.*

15.27.2 – *Revocations*

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

A. Revocation Reasons

The contractor may issue a revocation using revocation reasons *1-7 and 9-13* below without prior approval from CMS. Sections *15.*27.3 through *15.27.3.2* below address revocation reason *8* (42 CFR §424.535(a)(8)), which require*s r*eview and approval *by the Provider Enrollment Operations Group (PEOG).*

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

*R*evocation *Reason 1 (*42 CFR §424.535(a)(1))

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

Noncompliance includes, but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider or supplier has failed to pay any user fees as assessed under 42 CFR Part *488.*

Other situations in which the contractor shall use §424.535(a)(1) as a revocation reason include, but are not limited to, the following:

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

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

c. The provider or supplier is not appropriately licensed.

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

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

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

delegated official.

g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

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

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter. Note that the contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

*R*evocation *Reason 2* (42 CFR §424.535(a)(2))

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

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

If an excluded party is found, *the contractor shall* notify *its Provider Enrollment Operations Group (PEOG) liaison* immediately. *PEOG* will notify the Government Task Leader (GTL) for the appropriate *Zone Program Integrity Contractor*. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigatio*n.*

*R*evocation Reason *3* (42 CFR §424.535(a)(*3*))

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.

*A*n enrollment bar issued pursuant to 42 CFR §424.535(c) does not preclude CMS or its contractors from denying re-enrollment to a provider or supplier *that* was convicted of a felony within the preceding 10-year period or *that* otherwise does not meet all criteria necessary to enroll in Medicar*e.*

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact its Provider Enrollment Operations Group (PEOG) liaison for assistance.

*R*evocation *Reason 4* (42 CFR §424.535(a)(4))

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

Prior to revoking a provider or supplier’s Medicare billing privileges pursuant to §424.535(a)(4), the contractor shall contact its PEOG liaison for guidance.

Revocation Reason 5 (42 CFR §424.535(a)(5))

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

review, CMS determines that—

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

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

Revocation Reason 6 (§424.535(a)(6))

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

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

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

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

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

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

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

Revocation *Reason 7* (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 *that* enter into a valid reassignment of benefits as specified in 42 CFR § 424.80 or a change of ownership as outlined in 42 CFR § 489.1*8.*

Revocation Reason 8 (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.

Please see sections 15.27.3 through 15.27.3.2 of this chapter for instructions regarding the use of this revocation reason.

Revocation Reason 9 (42 CFR §424.535(a)(9))

The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.

Note the following with respect to Revocation 9:

- *This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.*

- *If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not revoke the supplier's billing privileges on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR §424.535(a)(5)(ii) or via another verification process - that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may revoke the supplier's billing privileges.*

Revocation Reason 10 (42 CFR §424.535(a)(10))

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

Revocation Reason 11 (42 CFR §424.535(a)(11))

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

Revocation Reason 12 (42 CFR §424.535(a)(12))

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

(Note that Medicare may not terminate a provider or supplier's Medicare billing

privileges unless and until the provider or supplier has exhausted all applicable Medicaid appeal rights).

B. Effective Date of Revocations

Per 42 CFR §405.874(b)(2), a revocation is effective 30 days after CMS or *its* contractor (including the *National Supplier Clearinghouse (NSC)*) mails the notice of its determination to the provider or supplier. However, per 42 CFR §424.535(g), a revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction as described in 42 CFR §424.535(a)(3), (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.

Note that in accordance with *42* CFR §424.565, *if a physician, non-physician practitioner, physician organization or non-physician practitioner organization* fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009. Moreover, no later than 10 calendar days after the contractor assesses the overpayment, the contractor shall notify its *PEOG* liaison of the amount assessed.

As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

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

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

C. Payment

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

D. Reapplying After Revocation

As stated in 42 CFR §424.535(c), after a provider, supplier, delegated official, or authoriz*ed official has* had their billing privileges revoked, they are barred from

participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar.

Unless stated otherwise in this section, the re-enrollment bar is a minimum of 1 year but not greater than 3 years, depending on the severity of the basis for revocation. The contractor shall establish the re-enrollment bar in accordance with the following:

1 year (AR 73) – License revocation/suspension that a deactivated provider (i.e., is enrolled, but is not actively billing) failed to timely report to CMS; provider failed to respond to revalidation request.

2 years (AR 74) – The provider is no longer operational.

3 years (AR 81) – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information.

For all other revocation reasons, the contractor shall contact its *PEOG* liaison. *PEOG* will establish the appropriate enrollment bar for that particular case.

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

Note also that reenrollment bars apply only to revocations. The contractor shall not impose a reenrollment bar following a denial of an application.

E. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(g), any physician, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

F. Reporting of Final Adverse Action - Compliance

If a physician or non-physician practitioner reports the imposition of a final adverse action (other than felony convictions) against him or her within the reporting timeframes specified in 42 CFR §424.516, and if the final adverse action is one for which the provider's billing privileges would typically be revoked, the contractor shall:

- Treat the submission as a voluntary withdrawal, rather than a revocation; and

- Establish an overpayment back to the date of the reportable event if the practitioner furnished services after the reportable event.

By reporting final adverse actions in a timely manner (i.e., 30 days), physicians and non-physician practitioners can avoid the imposition of an enrollment bar.

(As alluded to above, this policy does not apply to felony convictions. The contractor must revoke the provider's billing privileges in such cases even if the provider timely reported the conviction.)

(For purposes of this section, the term non-physician practitioner only includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; and registered dietitians or nutrition professionals.)

G. Notification to Other Contractors

If the contractor revokes a provider or supplier's Medicare billing privileges, the contractor shall determine, via a search of PECOS, whether the provider/supplier is enrolled with any other Medicare contractors. If the contractor determines that the revoked provider/supplier is indeed enrolled with another contractor(s), the revoking contractor shall notify these other contractors of the revocation. *T*he notification shall be done via e-mail and shall contain a short description of the reason for the revocation.

Upon receipt of this notification from the revoking contractor, the receiving contractor shall determine whether the provider or supplier's billing privileges should be revoked in its jurisdiction as well. Should the contractor need assistance in making this determination, it may contact its *PEOG* liaison.

H. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 19 of this chapter.

I. Summary

If the contractor determines that a provider's billing privileges should be revoked, it shall undertake the activities described in this section, which include, but are not limited to:

- Revoking the provider's billing privileges back to the appropriate date;
- Establishment of the applicable reenrollment bar;
- Updating PECOS to show the length of the reenrollment bar;
- Assessment of an overpayment, as applicable;

- Providing *PEOG* with the amount of the assessed overpayment within 10 days of the overpayment assessment; and

- Affording appeal rights.

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

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

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

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

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

Appeal Type:
CAP
Reconsideration
ALJ
DAB

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

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

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

Contractors shall submit their completed reports by the 20th of each month to its designated BFL or Liaison within the PEOG.

*15.*27.2.1 – *Special Instructions Regarding* Revocations *of Certified Providers and Certified Suppliers*

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

If the contractor determines that one or more of the revocation reasons identified in section *15.27.2 of this chapter* are applicable, the contractor may revoke the billing privileges of a certified provider or certified supplier without making a recommendation *for revocation* to the State and *CMS regional office (RO).* It can, in other words, revoke billing privileges at the contractor *level.*

In revoking the provider or supplier, the contractor shall:

- Issue the revocation letter to the *provider* in accordance with section *15.*27.2 *of this chapter.*

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

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

- Afford the appropriate appeal rights per section 19 of this *chapter.*