Session V: Advanced Provider Enrollment Issues
Medicare Provider Enrollment--It's Still Too Hard: Denials, Deactivations, Revocations and Appeals
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I. Introduction: In an effort to provide more depth and focus on provider enrollment issues, this paper focuses on what can go wrong with provider enrollment and the options that are available to right the wrongs. The issues addressed are:

a. What Can Go Wrong?
   i. Denial of Application
   ii. Rejection of Application
   iii. Deactivation
   iv. Revocation

b. Options for Righting the Wrongs:
   i. Dealing with the Medicare Administrative Contractor (MAC)
   ii. Corrective Action Plan
   iii. Request for Reconsideration
   iv. Request for Hearing before Departmental Appeals Board (DAB)

   i. Chapter 15 of the Program Integrity Manual now addresses all provider enrollment issues, including application requirements for specific types of suppliers and providers; site verification process; appeals process, etc.: https://www.cms.gov/manuals/downloads/pim83c15.pdf
   Note that Chapter 10 no longer contains provider enrollment information.

II. What Can Go Wrong?

a. Rejected vs. Denied Applications
   i. Denial of an application is different from rejection of an application (i.e. returned application).
ii. There is an appeal from a "denied" application.

iii. Rejected or Returned applications are treated as non-applications and there are no appeal rights for a rejection. (This is a major issue when the receipt date of the application establishes and/or affects the "effective billing date.")* See Practice Tip below.

iv. Contractors are authorized to reject and immediately return applications for the following reasons:

1. No signature on CMS 855 application
2. Application contains copied or stamped signature
3. **Signature on application is NOT dated.**
4. CMS 855I was signed by someone other than the individual practitioner or CMS 855B, 855R, 855S, or 855A was not signed by an authorized official.
5. Provider submitted version of application not currently accepted. (e.g. 855 application from 7/06)
6. For Medical group practices, applicant failed to submit all the forms needed to process reassignment package:
   a. Must submit 855I if individual not yet enrolled.
   b. **Initial enrollment of 855B must be accompanied by at least one 855R.**
   c. 855Rs must be accompanied by 855B if the group has not yet been enrolled in Medicare.
7. Part A Change of Ownership (CHOW) applications for new or old owner submitted more than 3 months before anticipated date of sale listed in 855A.
8. **Part B supplier applications (855I, 855B, 855R) received more than 30 days prior to effective date listed on application.**
9. Application submitted for sole purpose of enrolling in Medicaid unless the provider is required to submit a Medicare cost report in order to participate in State Medicaid program.
10. CMS 855 application not needed (most common-individual physician submits an 855I at the same time the physician submits an 855R to reassign to new group and there are no changes in the 855I application).
   a. Practice Note: It is helpful for physicians to complete an 855I change of information application to update their correspondence addresses when reassigning to new groups.
b. Physicians should also submit 855R applications to terminate old reassignments or individual practice PTAN numbers.

c. Caveat: Some MACs mistakenly treat the 855I change of information applications as superfluous if the physician already has a record in PECOS and these changes are not always processed. (Basically the processors miss the fact the physician is changing information).

d. If a physician is reassigning to a group that has more than one PTAN number under a single lax ID number, only one 855R is required, but we recommend sending a separate 855R for each PTAN to ensure that the notification letter, which contains the newly issued PTAN numbers, are issued for each group PTAN number. Some MACs have difficulty issuing separate PTAN numbers when only one 855R is filed.

11. CMS-588 sent without signature, date and/or contained copied signature. (When a CMS-588 is required to be filed with an 855 application, the 855 application can be denied if the CMS-588 application is not sent in timely after the "lacking notice" is sent.)

*Important Practice Note on Rejections: Not all rejections are correct and not all rejections are immediate. Look carefully at the rejection and see whether it was a correct rejection. If the rejection was wrong, seek out a Provider Enrollment Manager or Director to explain the MAC's erroneous rejection and request that they re-accept the application with the original receipt date. If the "immediate return" occurred months after the submission, attempt similar contact and request that the date be reset so that your provider does not lose ability to bill. (worth a try, but not guaranteed to be effective).

b. **Application Denials** (PIM 15.8.4)

i. 42 C.F.R. 530(a) and PIM section 15.8 set forth the reasons for denials, which are as follows:

1. Incomplete applications (applies to individual practitioners and their Part B groups).

   a. For these entities, the applications can be denied if requested information is not provided within 30 days of the request being made.

   b. The MAC has discretion to extend the 30-day time period if the provider/supplier is actively working with the MAC to resolve outstanding issues.

   c. There are no REJECTIONS of applications from these individuals or organizations. (PIM 15.8.4.1 effective 10-26-10)
2. Provider or supplier is determined not to be in compliance with Medicare Enrollment requirements and did not submit a Corrective Action Plan in accordance with 42 CFR part 488.

3. Provider, supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician or other health care personnel who is required to be reported on the CMS 855 is:
   a. Excluded from Medicare, Medicaid or any other Federal health care program.
   b. Debarred, suspended or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

4. Provider, supplier or any owner was, within 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 or its beneficiaries, including:
   a. Felony crimes against persons: murder, rape, assault, including guilty pleas and pretrial diversions.
   b. Financial crimes: extortion, embezzlement, income tax evasion, insurance fraud or other similar crimes.
   c. Any felony that place 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. Felonies outlined in section 1128 of SSA.

(PRACTICE NOTE: Denials for adverse activity of a particular owner, managing employee, an authorized or delegated official etc. may be reversed if the provider/supplier submits proof of termination of the business relationship within 30 days of the denial notification PIM 15.8.4 (D)).

5. Submitting false or misleading information on the enrollment form.

6. Onsite review or other reliable evidence leads CMS to determine that the provider or supplier:
   a. Is not operational (e.g., lack of required license; no physical business address or mobile unit where services can be rendered);
   b. Does not have a place where patient records are stored;
   c. Does not meet certification for specialty (e.g. Clinical Nurse Specialist with no Masters in Nursing).
d. Provided invalid SSN/EIN provider for applicant, owner, partner, managing organization/employee, officer, director, medical director, and/or delegate or authorized official.

e. Home Health agency does not meet capitalization requirements.

ii. In the situations listed above the MAC must give the supplier/provider written notice of the denial, specific reasons for the denial and notice of the appeal rights. The provider/supplier should have the opportunity to submit a Corrective Action Plan and/or request for reconsideration and appeal rights.

iii. No Enrollment Bar is established for denied applications but an reenrollment bar may be established separately based on occurrences such as felony convictions and licensure suspensions that were not reported timely.

iv. NOTE WELL: No new application can be submitted for a denied application until:

1. The provider and/or supplier's appeal rights have lapsed.

2. If the denial was appealed, the provider/supplier may reapply after it received notification that the determination was upheld.

v. PRACTICE TIP: Read letters very and look very at whether the reason stated can be corrected and/or disproved. WATCH THE DEADLINES. 30 days for a CAP and 60 days for Request for Reconsideration. See discussion below concerning whether to file a Corrective Action Plan and/or a Request for Reconsideration.

c. Deactivation of Part A or Part B numbers (PIM 15.27)

i. MACs may deactivate a part A or part B provider number for one of the following reasons:

1. Provider or supplier does not submit a claim for 12 consecutive full calendar months. (Calculated as the first day of the first month without a claim through the last day of the 12th month without a claim). (PIM 15.27.1(a)).

2. Provider or supplier fails to report change within 90 calendar days (e.g. change of practice location, change of managing employee or change of billing service).

3. Provider or supplier fails to report change of ownership or control within 30 days.

4. Provider or supplier submits an application and fails to provide lacking information within 30 days after it was requested by the Contractor or if the Contractor is unable to confirm the changes being submitted by a particular change of information request. (PIM 15.27.1).
ii. Deactivation does not affect the Participation Agreement (CMS-460).

iii. To reactivate a Part A provider number, the provider must file an 855A application. The existing provider number is reactivated and the billing privileges are restored without affecting the "effective billing date."

iv. To reactivate Part B billing privileges (except DMEPOS; ASC, or portable X-Ray):

1. PIM states that the Part B supplier must submit the appropriate CMS 855B, CMS 855I, and/or CMS 855R applications.

2. The old PTAN numbers are terminated and new PTAN numbers are issued.

3. In most cases, the new PTAN numbers have an effective billing date that is the later of the first day services were provided at the location or 30 days before the date the new 855 applications were received by the MAC. (Major problem discussed below because PIM is at odds with Medicare rules)

4. If the billing privileges were terminated for a group or individual that provides Medicare services under more than one PTAN number under a single Tax Identification Number and the 12-month billing gap did not apply to all PTANs held by the provider, the effective billing date for the new PTAN number should be the end date of the old PTAN number.

5. QUESTION for CMS: May a deactivated supplier be paid for services rendered in the period of time prior to deactivation if the supplier does not file the appropriate CMS 855. (E.g., clinic did not bill for services for 12 months for PA. PA's PTAN number was deactivated on 1/1/2010, but the PA provided services prior to 1/1/2010. Will the practice get paid claims it submits for services that predate 1/1/2010?)

6. If Supplier wants to continue to submit claims for services provided after the date of deactivation, the supplier must obtain a new Part B PTAN number with effective date being the date after the first PTAN number was terminated.

v. To reactivate billing privileges for a DMEPOS supplier,

1. The DMEPOS supplier must submit the 855S application and obtain approval of the application from the National Supplier Clearinghouse (NSC).

2. Show proof of accreditation.

3. Undergo a new site visit.

4. The effective billing date will be after all these steps have been completed, which can be many months.
vi. IMPORTANT CAVEAT: THERE ARE NO APPEAL RIGHTS FOR DEACTIVATION.

1. For Part A providers, the lack of appeal does not pose any real problem beside a temporary adverse effect on cash flow. This is because the "effective billing date" does not change and the provider retains the ability to be paid for services provided in the period of time between deactivation and filing of 855A application to reactivate billing privileges.

2. For Part B suppliers, the lack of appeal denies suppliers the ability of obtain reimbursement for services provided in the period of time between deactivation and reactivation of Part B PTAN numbers.
   a. This is also significant because the rules governing deactivation for failure to bill for 12 months indicate that they were adopted to protect the individual supplier as well as the Medicare Program. 42 CFR 424.540 (as adopted 71 Fed. Reg. 20776 (4/21/2006)).
   b. The rules indicate that the PTAN number would be reactivated once the 855 application information is verified. The rules contain no language indicating intent to require the practitioner 7 or Part B group to go back through the Medicare Enrollment process. Nevertheless, the effect of the process that CMS has instructed MACSs to follow denies the suppliers the right to bill for services even though their Medicare Participation Agreement remained in effect. 42 CFR 424.540 (as adopted 71 Fed. Reg. 20776 (4/21/2006)).
   c. In practice, suppliers generally do not find out that their supplier number has been deactivated until they attempt to submit claims and the claims are rejected. By this time, they have difficulty submitting an application soon enough to avoid the gap in the ability to bill for services. The MAC instructs the supplier to submit a new 855B or 855I and 855R application to obtain a new PTAN number. The new PTAN number is effective 30 days prior to the receipt. If more than 30 days lapsed between the receipt date and the effective date of the deactivation, the supplier will lose the ability to be paid for those services.
   d. It appears that the rules concerning initial enrollment and effective billing date are being misapplied to deactivations. The only reason that deactivation should have no appeal rights is that deactivation should not deprive the supplier payment for services rendered. 42 CFR 424.520, 424.521; 73 Fed. Reg. 66940 (11/19/2008).
   e. Deactivation Cases
A physician assistant's PTAN number was deactivated while he served for over one year in Iraq. When he returned to his job at medical group, claims for his services were denied because his PTAN number had been deactivated. His group appealed the deactivation and gap in payments. Regardless of the alleged denial of appeal for deactivation cases, the DAB permitted the appeal as it related to the effective date of the new PTAN. The ALJ decision nevertheless upheld the new effective date set the MAC. Wardell v. CMS, CR 2091 (DAB 3/19/2011). It, however, appears that Wardell or his group did not know to raise the regulatory misinterpretation so the ALJ did not consider the argument raised here.

1. PRACTICE NOTE: In reassignment cases, it seems that the group should have the right to appeal issues related to individuals for whom it has reassigned and the right to receive payment. In practice the appeal must be made in the name of the individual whose PTAN number is deactivated or revoked.

While deadline for effective date of privileges is appealable, CMS/MAC action in deactivating a billing number for failure to send claims in 12 month period of time is not appealable. Case states that a new enrollment must be filed even though the actual language of the rules and commentary does not require a new application. Mobile Vision, Inc. v. CMS, CR 2124 (DAB 4/27/10) (DMEPOS).

It, however, appears that the group did not know to raise the regulatory misinterpretation so the ALJ did not consider the argument raised here.

Given the deactivation rules are being interpreted in a way that causes a supplier to lose the ability to bill for services provided, the supplier must be entitled to an appeal. Here's a possible appeal argument:

i. The deactivation action was appropriate based on the rules.

ii. The effective date of reactivation is what is at issue. Given the rules, the reactivation date should be the day of or the day after the deactivation because the rules merely require that the supplier confirm the information in its enrollment record.
g. In recent DAB appeals, it appears the parties are starting to raise the arguments above. The ALJs are recognizing that they cannot hear an appeal concerning the imposition of the deactivation, but they can consider an appeal concerning the effective date for billing privileges. (See summary regarding Aldredge v. CMS, CR2351 (April 8, 2011); Kim v. CMS, CR 2431 (9/16/11) & Hwang v. CMS, CR 2394 (7/8/11) (Deactivation date appeals dismissed after CMS changed effective date as requested by parties based on arguments that regulations not meant to subject practitioners to loss of ability to submit claims); But see Bafna v. CMS CR 2419 (8/23/11) (denying request for retroactive billing effective date in deactivation for nonsubmission of claims for 12 months).

3. For DMEPOS suppliers, the effect of deactivation is even more devastating because the effective date of billing services will be after the supplier meets the accreditation requirements and undergoes a new site survey.

d. **Revocations** (PIM 15.27.2)

i. Revocations have been occurring with increasing frequency since the change in provider enrollment rules that took effect on 1/1/2009

ii. Major causes of revocations:

1. Failure to respond to revalidation requests issued to Part B individual practitioners and groups. This basis for revocation reached its peak in 2009, but it remains a possible basis for revocation as periodic revalidation initiatives occur.

   a. PRACTICE NOTE: The current revalidation effort that began in September 2011 as required under PPACA does not impose revocation if a practitioner fails to revalidate. Instead the practitioner's PTAN number will be deactivated until the revalidation applications are submitted.

   b. Although deactivation is being used for the PPACA revalidation, the MACs have indicated that revocation may be imposed on revalidation requests made in accordance with other Medicare regulations and/or initiatives. (See PIM 15.27.2(A) (Reason 10); 42 C.F.R. 424.535(a)(9)).

2. Contractor site visits that identify closed/nonoperational practice locations. (See PIM Chapter 15, section 20).

3. Closure of a Bank account and provider/supplier's failure to provide new EFT/bank account information within 90 days of the date that the Contractor first learned of the closed bank account. (PIM, Chapter 15, Section 11 (7) (Closure of Bank Account)).
4. Failure to report licensure suspension or revocation.

a. **MAJOR PRACTICE POINT FOR ATTORNEYS REPRESENTING PRACTITIONERS EXPERIENCING SUSPENSION/REVOCATION OF CLINICAL LICENSES**

i. Revocation of Medicare billing number is retroactive to date of license suspension or revocation.

ii. Later lifting of suspension does not absolve practitioner from the duty to report suspension and face revocation of number.

iii. Practitioner will lose the ability to bill for unbilled services prior to suspension or revocation if practitioner does not self report suspension. *Brown v. CMS*, CR 2145 (6/19/2010) (medical licenses of two physicians were summarily suspended on 4/19/09 and suspension was lifted on 5/6/10; revocation upheld because suspension was not reported; 1 year enrollment bar imposed).

iv. Practitioner, who practiced in Texas and was enrolled in Medicare through Texas practice location, was under Board Order from Texas Medical Board (TMB). Practitioner also had a California license and California sought to take action against CA license based on TMB order. Practitioner did not have resources to deal with California and understood California would adopt Texas Board Order provisions, but instead, CA revoked CA license. Medicare billing privileges revoked by CMS/Trailblazer in Texas for loss of license in California. *Kinzie v. CMS*, CR 2112 (April 12, 2010).

5. If a physician or practitioner reports a final adverse action voluntarily (e.g. loss of license), then the MAC can treat it as a voluntary withdrawal rather than a revocation and establish an overpayment date that goes back to the date of the reportable event if the physician furnished services. If it's done time, the practitioner can avoid imposition of the enrollment bar. (This policy does not apply to felony convictions.)

6. DMEPOS providers noncompliance with DME standards


b. Other standard violations identified during site visits or contractor checking:
i. Failure to have hours posted or not consistent with 855S.

ii. Site not opened during time listed in application.

iii. Phone answered by answering service or number different from that listed in 855S application.

iv. Violation or noncompliance with any other of the 30 standards.

7. Provider/supplier knowingly sells to allows another to use its billing number (not applicable to reassignment or change of ownership).

8. Adverse legal Actions/Convictions.

a. Must be reported within 30 days.

b. Felony by co-owner or controlling person could lead to revocation even if controlling person removed by sale or leaving supplier. *Main St. Pharmacy*, LIC, DAB Dec. 2349 (12/13/10). (Despite sale of partnership interest back to co-owner, CMS revocation of DME supplier number related conviction of coowner was upheld. Evidence of remaining owner's cooperation with federal investigation was unpersuasive in getting revocation rescinded.) *(Like Practice Note above under Application Denials, MAC has permissive authority to rescind a revocation if supplier/provider reports cuts loose the wrongdoer within 30 days of receiving notice of the revocation for this reason. PIM 15.27.2(8)).*

c. If felony or misdemeanor imposed against a person or entity is disclosed in the 855 or if a felony or misdemeanor is found by the MAC, then the application is referred to the contractor's DPSE

d. CMS may refer the matter to:

i. OIG

ii. Program Safeguard Contractor (PSC)

iii. Zone Program Integrity Contractor

iv. Approval and Denial cannot proceed until the DPSE issues a final directive to the contractor, unless the applicant has been excluded or debarred.

v. If one provider is denied based on the actions of an individual, the contractor is required to check
PECOS and its internal systems for providers not in PECOS and determine whether the individual or provider has any other associations with Medicare providers.

vi. The other Medicare providers may have their billing privileges revoked. (p.36)

vii. If the individual is associated with other providers who are under different contractors, then the contractor must notify the other contractors to take action.

9. Note that starting 9/5/2010, Contractors are required to report revocations to CMS which in turn will notify State Medicaid agencies and child health plans or revocations due to felony adverse actions and noncompliance. (PIM, Chapter 15, Section 27.2)

10. Enrollment Bars- With revocations, providers and suppliers are being subjected to enrollment bars for 1-3 years. The following the bases for the various time frames:

a. **1 year**: License revocation/suspension of deactivated provider/supplier that was enrolled but not actively billing; provider/supplier failed to respond to revalidation.

b. **2 year**: Provider/supplier is no longer operational.

c. **3 year**: Medical license revocation/suspension and practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and practitioner continued to bill Medicare after date of the conviction; falsification of information.

d. **Other reasons**: For instances not covered above, the DPSE will establish the appropriate bar.

11. **Submission of Claims furnished before Revocation**:

a. IDTFs, group practices, or individual practitioners must submit claims for services provided before effective date of revocation within 60 days of the effective date of revocation. (Problem is that with certain revocations, such as those based on site visits, the group/practitioner may not find out the revocation was imposed until more than 60 days after the revocation took effect.

**See attached Analysis of Appeal deadlines: Deadlines are short and are subject to change.**
HOW CAN YOU RIGHT THE WRONGS?

III. Dealing with the Contractor

a. When a supplier or provider gets notice of a rejection, deactivation, denial or revocation, it is worth contacting the Contractor to determine whether the Contractor can take action to address an incorrect action.

b. In exercising this option, the provider or supplier must remain aware of the applicable deadlines for filing Corrective Actions Plans and Requests for Reconsideration.

c. While this can be an effective, time-saving and efficient way to reinstate billing privileges, it is also fraught with danger as apparent from numerous horror stories that are circulating by word of mouth and are documented in the Departmental Appeals Board decisions.

i. Anecdote:

1. Practitioner was revoked related to a site visit because correspondence address and practice location on record with Medicare since mid 1990s were a private post office service. Solo practitioner provided services to individuals in assisted living settings and nursing homes. Upon receipt of revocation notice, practitioner notified MAC and asked what to do. CAP and request for reconsideration instructions did not really give the practitioner a good idea about what was required. The MAC contact instructed practitioner to file new 855 app and new PTAN was granted. Practitioner had difficulty setting up electronic billing under the new PTAN. MAC representative finally told practitioner that new PTANs had been issued in error, but never sent a written notice regarding the status of the new PTANs. By this time the 30/60 days deadlines had passed to challenge the revocation. Request for hearing filed with DAB and prehearing order was issued. Matter was resolved with Regional Counsel.

2. Solo Practitioner was revoked because for alleged failure to respond to a lacking letter related to the CMS 588 EFT form filed with an 855I revalidation submission. The practitioner completed the second page of an older version of the EFT form in error by inserting his own name instead of the MAC. The Lacking letter faxed to practitioner did not include the page that identified what was lacking. Practitioner called the MAC and was told CMS 588 EFT form was missing (there was no mention of an error.) Practitioner resent the 588 completed in the same manner with a new signature and heard nothing more until his electronic claims began rejecting. He called MAC again and found out his enrollment had been revoked. He received no notice of revocation. He was told to file a new 855I and CMS 588 form. Those were rejected because he was under an enrollment bar and the time frame from the notice that he never received had passed the 60 day mark. This case was resolved with contact to CMS Central office.
ii. DAB Case: A group was established for advanced practice nurses (APRNs) to provide services to patients. The MAC allegedly told the group that the group had to be established before 27 APRNs could file their 855R reassignments. The group was established effective in March 2009 and then the APRN 855R applications were filed. The filings resulted in a gap for the APRNs being able to bill because they had waited for the group number issue and they could only bill for services up to 30 days before the 855R applications were received. The evidence of wrong advice given twice by the MAC was not persuasive in getting the reassignment effective dates reset to be same effective date as initiation of the group. Go v. CMS, CR 2136 (May 21, 2010).

IV. Corrective Action Plans

a. Corrective Action Plans are good and bad. To the good, they might be processed more quickly than a request for reconsideration because the SOM sets forth a shorter time frame for resolution; to the bad, they may result in a later billing effective date than a request for reconsideration.

b. The purpose of the Corrective Action Plan is to correct an identified error in the process that was committed by the applicant (e.g. failure to report closure of practice location; failure to revalidate timely; failure to report change in controlling persons that was identified and led to the revocation; failure to respond to request for follow up information that led to denial of an application). (See PIM Chapter 15, section 25)

c. For denials, the effective date used is based on the date the provider or supplier came into compliance with all Medicare requirements or the receipt date of the application. For a new PTAN the effective date will most likely be date of the receipt of the corrected application and the provider can back bill up to 30 days before the receipt of the CAP.

i. For DMEPOS suppliers, the effective date is date that NSC recommends approval. The action, however, must be approved by CMS before billing privileges are restored. (Substantial delay).

d. For revocations, a properly filed and could lead to rescission of the revocation and reinstatement of the former billing privileges date.

e. All CAPS for certified suppliers are supposed to be submitted to CMS Baltimore:

   Centers for Medicare & Medicaid Services
   Division of Provider & Supplier Enrollment
   7500 Security Blvd.
   Mailstop C3-02-16
   Baltimore, MD 21244-1850

   For other providers/suppliers follow instructions in notice letter.

f. What is the corrective action plan (CAP)?

i. There is no good guidance in the notice letters or the rules about what constitutes a CAP. Providers and suppliers are merely directed to the rules about CAPs and even the PIM is not very helpful. CR 6248/Transmittal 275 from December 28, 2009, appears to limit the use of CAPs to providers and certified suppliers, even though the CAP
process is available to "non-certified" suppliers such as Part B groups or individual practitioners. Hence, the initial reaction to call the Contractor and find out what should be done and the advice is not always reliable as described above.

ii. PIM 15.25(A) provides a bit more guidance on CAPs:

1. MACs are supposed to advise providers that the submission of a CAP will expedite the enrollment process and lead to a faster determination (not recently with Trailblazer).

2. CAP should be in the form of a letter and contain at minimum verifiable evidence of provider/supplier compliance.

3. MACs may create a standard CAP form to be sent out with denial letters.

4. If approved, billing privileges can be issues. The effective date is based on the date that the provider/supplier CAME INTO COMPLIANCE or the receipt date of the application or CAP receipt date.
   a. For DME, the effective date is the date given by NSC after CMS approval.

5. PIM says that CAPs "shall" be processed in 60 days. Recently, Trailblazer posted processing time for CAPs that exceeded 150 days.

6. Appeal deadlines ARE NOT tolled during CAP processing, but MAC could make a good cause determination to accept any appeal filed beyond timely filing deadline.

7. If a CAP and Request for Reconsideration are submitted concurrently, the CAP must be processed first. The Request for Reconsideration is processed afterwards by the Hearing Officer unrelated to the initial determination or the CAP determination.

iii. With lack of clear guidance, I just have my own experience as basis for what has been accepted as a CAP. My experience is based on CAPs filed with Trailblazer and National Supplier Clearinghouse.

iv. The CAPs I have helped file consisted of a letter explaining the background of the denial or revocation, the steps taken to file an 855 application (that accompanies the letter) to address the alleged error, any arguments I have as to why the alleged error actually was not an error to preserve the request for reconsideration. The letter will also identify the steps the supplier has taken to assure compliance with provider enrollment requirements in the future, such as:


2. An acknowledgement that the practitioner and key staff are aware of deadlines and filing requirements.
3. Additional steps taken to assure compliance by periodic checking and confirmation of information on file with MAC.

v. Some MACs, like Trailblazers, have a form that must be filed with a CAP. The form helps the MAC distinguish those 855 applications that are filed as part of a CAP and those that are simply new filings. It appears that many MACs consider the filing of the "corrective" 855 and/or 588 forms as constituting the entirety of the CAP.

1. I believe many of the problems with dealing with MACs concerning CAPs is that the MACs had no processes in place to handle CAPS and they ended up rejecting "corrective" CMS 855 filings as being barred due to enrollment bars that accompanied revocations rather than recognizing them as CAPs filed in response to revocation notices.

2. MACs continue to revise their processes and make changes that may be inconsistent with CMS guidance. I was recently told that a CAP and Request for Reconsideration must to be filed separately, despite the fact I had filed numerous CAPs/RfRs together and was given no notice that a particular RfR had not been accepted. I was able to "refile/amend" my RfR and it was processed favorably.

3. CAP for all provider/suppliers must be signed by individual provider, delegated or authorized official, or legal representative.

g. DEADLINE FOR CAP DECISION:

vi. According to Chapter 15 of the PIM, the Contractor must make its decision on the CAP within 60 days from the date of submission.

vii. CAPs are not being decided within 60 days. In February 2012, Trailblazers average time for responding to a CAP was 161 days.

viii. Make sure the client's right to request for reconsideration is preserved by filing the Request for Reconsideration within 60 days of the date of the original notice of denial/revocation.

ix. CAVEAT: There are no appeals from the rejection of a CAP even of the CAP was rejected in error. *Anjum v. CMS* (CR 2462 Nov. 7, 2011)

V. Request for Reconsideration

a. Like CAPs, there is no good guidance for what constitutes a Request for Reconsideration.

b. Deadline for submission of RfR is 60 days from date of notice of denial or revocation.

c. If an RfR is submitted after the deadline, the Hearing Officer is required to make a finding of good cause before taking any other action related to appeal.

i. Time limits may be extended if good cause for late filing is shown.
ii. Reasons:

1. Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; OR

2. Destruction by fire or other damage of the individual's records, and such destruction was responsible for the late filing.

d. Based on experience, Requests for Reconsideration should contain the following information:

i. Identification of the Provider or Supplier at issue (NPI/PTAN)

1. For Reassignments to a group, identify the individual practitioner (individual NPI/individual PTAN if assigned) and the group (organization NPI and group PTAN).

ii. Restate the contractor's alleged basis for denial/revocation and include wording of regulation cited.

iii. Provide background and the area of concern:

1. Identify the applications filed that led to the denial and provide copies of the applications; OR

2. Identify the problem that led to the revocation and why the provider/supplier did not violate the identified regulation or standard. (Consider if additional documentary proof is needed.)

iv. Set forth arguments the show the enrollment application was incorrectly denied or that the billing privileges were revoked erroneously.

v. The scope of the review is limited to the Medicare contractor's state reason for imposing the denial or revocation and whether that was the correct reason.

vi. Contractors cannot introduce new denial or revocation reasons or change a denial/revocation reason during the reconsideration process.

vii. Proof of later achievement of compliance and/or regulations that show standard was applied in error.

viii. Clearly identify the action that is requested and the date that should be used for the effective date of Medicare billing privileges.

1. Revocation rescinded.

2. Denied application should be processed to completion with retroactive effective date that is 30 days before the date the application was received by the Contractor.

ix. Request for Reconsideration letter must be signed by the individual, the attorney for the individual or entity, or authorized/delegated official of the entity. Besides attorneys, there are no other "authorized/delegated"
officials for an individual who are not already listed in an 855 enrollment form for the provider/supplier. For DMEPOS providers, the PIM does not list legal representatives as persons being able to sign a request for reconsideration. (That might be a drafting error.)

e. Like CAPS, all Requests for Reconsideration related to certified suppliers are supposed to be submitted to CMS Baltimore:

   Centers for Medicare & Medicaid Services
   Division of Provider & Supplier Enrollment
   7500 Security Blvd.
   Mailstop C3-02-16
   Baltimore, MD 21244-1850

   For other providers/suppliers follow instructions in notice letter.

f. If provider or supplier receives information from Hearing Officer about the Request for Reconsideration, it is worthwhile to communicate with hearing officer to see if additional information is needed. (In one case, the issue that was identified in accordance with the regulation was not the issue the hearing officer identified. It helped the client to provide additional information about the issue identified by the hearing officer and I also preserved the regulatory issue by presenting those arguments as well).

g. The PIM states that the HO conducting the review should be knowledgeable about provider enrollment and not involved in the original decision. Also the reason for imposing the denial must be limited to that provided in notice letters to the client. The MAC may not introduce new reasons or change reasons for denial or revocation once the request for reconsideration is filed. The provider, however, may introduce new evidence of compliance prior to denial/revocation or error by the MAC.

h. Decision deadline: the decisions on requests for reconsideration are supposed to be made in 90 days from the date of the appeal request.

VI. Departmental Appeals Board (DAB) Appeal Process

a. If the Request for Reconsideration results in a decision adverse to the provider or supplier, the provider or supplier has 60 days from receipt of the written notice of the adverse decision to file the appeal with the Departmental Appeals Board (DAB). The appeal is a "Request for Hearing" with the Civil Remedies Division.

b. If the provider or supplier is subjected to an adverse action and never receives a written notice or written notice of the appeals rights, the provider or supplier may still file a "Request for Hearing."

c. The Request for Hearing is basically a letter to the DAB Civil Remedies Division that sets out the following information:

   i. Parties-

      1. Identification of the petitioner should include the Name, Medicare PTAN number and NPI number.
2. Opposing Party is CMS acting through the identified contracted representative. Provide address for the contractor.

ii. Basis for Dispute

iii. Procedural Background

iv. Standard of Review

v. Issues for Appeal/Argument

vi. If applicable, Explanation of timely filing of appeal and/or good cause for extended time to file appeal.

vii. Relief requested.

viii. Copy of Written Notice giving rise to Request for Hearing.

d. CMS is represented by attorneys from the Office of the General Counsel (OGC) Regional Office that has jurisdiction over the state whether the provider or supplier is locations.

e. Assuming the DAB accepts the request as being a valid "Request for Hearing," the DAB will issue an "Acknowledgment and Pre-hearing Order" that generally gives the attorney for CMS 30 days to provide the following:

i. A list of all proposed exhibits, including any written direct testimony of any proposed witnesses.

ii. A copy of each proposed exhibit.

iii. A list of all proposed witnesses (if any).

iv. A copy of any prior written statement by any proposed witness even if CMS does not intend to offer that statement as an exhibit.

v. A brief, summarizing all issues of law and fact, including any Motion to Dismiss or Motion for Summary Judgment.

f. The Petitioner has 30 days from receipt of CMS's exchange to provide the same items to CMS.

g. CMS's response to any Motion for Summary Judgment by Petitioner is due within 15 days.

h. Petitioner has the right to cross-examine any witness whose written direct testimony is offered by CMS. Petitioner's request to cross examine any witness must be included in Petitioner's brief.

i. Case is considered closed after the exchange unless an in person hearing is needed for cross-examination.

j. Next level appeal: DAB Hearing
i. CMS, Medicare contractor, or provider/supplier dissatisfied with ALJ hearing decision may request Board review by the DAB.

ii. Request Deadline: 60 days after receipt of the ALJ's decision.

iii. Failure to request DAB is deemed a waiver of all rights to further administrative review.

iv. DAB may admit additional evidence if the DAB considers it relevant and material, but DAB must give the parties notices that it will receive additional information.

k. There had been a very large number of provider enrollment appeals in 2009 and 2010. During that time DAB Board Member Leslie Sussan handled all of the cases. Since October 2010, Administrative Law Judge Joseph Grow has been handling the cases.

l. Do you really win if the decision is made that provides Medicare billing effective date that is more than 12 months back?

i. Under PPACA, the deadline for filing claims is 12 months from the date the service was provided. Previously a supplier could submit claims for up to 27 months after the service was provided.

ii. The regulation 42 C.F.R. § 424.44(b) has always allowed for a 6-month extension following a notice of "governmental error."

iii. This deadline has existed because the filing deadline would expire before the provider or supplier became eligible to bill Medicare or (more commonly) the individual who received treatment became entitled to Medicare. Someone who is disabled under title II of the Act is entitled to Medicare coverage up to 24 months after becoming entitled to Title II disability benefits. The statute provided for the government error exception, which was incorporated in 424.44(b) to deal with the situation where a physician treats an individual, who at the time of treatment, has not established entitlement to disability benefits and thus has not established entitlement to Medicare, but who subsequently prevails in a disability appeal, which can take years, and establishes entitlement to disability and Medicare prior to the date of treatment. Without the governmental error exception the physician or the individual would not be able to file a claim because the time to do so would have since run. Although the foregoing situation was the genesis for the exception, it should be applicable any time that governmental error caused someone to be unable to file timely a claim for benefits. (Analysis Courtesy of Don Romano of Foley Lardner, Washington DC).

VII. Judicial Review

a. Appeal from DAB decision, can be made by filing a civil action in a United States District Court.

b. Filing deadline: 60 days from receipt of notice of DAB's decision.