

**WARNING: MEDICARE PART B REVOCATIONS ARE COMING TO A
PHYSICIAN, GROUP PRACTICE OR DME SUPPLIER NEAR YOU**

(This was a posting on the American Health Lawyers Association's listserv on June 19, 2010. It is quoted verbatim below. This is provided for information only and is not legal advice.)

We are seeing an increase in Part B revocations and the effects are devastating on a professional and emotional level. You could beat a practitioner with a 2 X 4 [two by four] and cause less pain to the individual than is caused when he/she receives a revocation letter. Also, imagine how hard it is to render care to medicare patients or any other patients for that matter after a doctor has just gotten a letter that says his or her provider number has been revoked.

The major reasons the revocations are occurring is due to revalidation requests and site verifications.

1. Revalidations: In Fall 2009, individual part B practitioners were sent revalidation requests to complete 855i and CMS-588 forms. This mass mailing was done about November 2009 so that most individual part B practitioners (physicians, podiatrists, etc.) will be in PECOS by the time to the ordering/referring provider initiative is completely implemented in January 2011 (it was postponed several times from the original effective date of October 1, 2009). Under this initiative, claims for services that require an ordering/referring provider will be rejected and not paid if the ordering or referring provider is not in PECOS (e.g., order for X-ray services for a radiology, clinic or IDTF).

a. The letters were sent by regular mail. Some practitioners did not receive them. Here are the reasons [that have been] heard or seen:

i. Letter was sent to a practice location that does not have a mail box to receive mail.

ii. Letter was sent to an old address for the practitioner.

iii. Letter was not delivered by the postal service to a legitimate address because the address did not include the name of the practice.

iv. Address convention had changed since provider filed original application (renamed road, changed zip code etc).

v. Letter was not received and unclear why.

vi. Letters are not sent certified, return receipt requested. Letter is assumed received.

b. If the revalidation 855 and/or 588 weren't submitted within 60 days, the

practitioner's Medicare enrollment was revoked and the practitioner was barred from reenrolling in the Medicare program for one (1) year from the date of the notice letter. The practitioner is given the option of submitting a corrective action plan (CAP) and/or request for reconsideration. See below for discussion of that process.

2. Site verifications: This is a very scary process. Contractors are going to all the practice locations listed in a part B application (group and individuals). If the site survey identifies a practice location that is closed, the group's provider number is revoked retroactive to the date of the site verification survey.

a. Some times notice is quick (within two (2) weeks of the survey) and sometimes it is late (two (2) months after the survey).

b. We are seeing situations where a practice location was closed six (6) years past and that is subjecting the practice to a revocation.

c. We are seeing re-enrollment bars of three (3) YEARS for part B groups; two (2) years for DME site verifications.

d. The groups and practitioners are being given the option to submit a CAP (30 days) and/or reconsideration request (60 days).

e. Check out recent CR from April concerning site verification process.

3. CAP and Reconsideration Process. The notice letter gives the practitioner the right to submit a corrective action plan (CAP) and request reconsideration.

a. Corrective Action Plan: There is little guidance about what the corrective action plan should be, but here's what [was] learned:

i. The practitioner has 30 days from the date of the revocation notice letter to submit a corrective action plan.

ii. Complete the corrective action plan form on the MAC's web.

iii. Provide a letter signed by the practitioner explaining what happened and how the practitioner has changed his/her practice and understands all that is required to maintain accurate provider enrollment information (i.e., will submit CMS 855i as required for change of information).

iv. Provide a complete 855i form that is signed and dated.

v. If the CAP is denied, there is NO APPEAL from the

Denial. Next step is the Request for Reconsideration.

vi. If the CAP is accepted, the revocation is rescinded and the practitioner's billing rights are restored back to the original effective date with no loss of ability to submit claims.

vii. Note some CAPs are not approved until there is a site verification. Here are some components of site verification that can cause problems:

1. Telephone number is tied to location (some checks on 411 are inaccurate and it's not clear how the phone number is tied to the site).

2. Phone calls are made to the numbers and there can be a problem if an answering service answers the number instead of the provider's staff.

a. For DME, posted hours must match exactly with the hours in the application and the supplier must post a temporary out of office with time of return listed on the sign.

b. Unclear how MAC will deal with practice locations that are done on a time share basis (e.g., one afternoon a week) and there is no signage.

b. Request for Reconsideration:

i. The practitioner has 60 days from the date of the revocation letter (NOT the date the CAP is denied) to submit the request for reconsideration.

1. . . . According to Program Integrity Manual and the regulations, it appears that the reconsideration request will only be successful if the practitioner can show that the initial revocation was done in error. It is also not clear if you can use the reconsideration process to address problems that caused CAP to be denied.

a. The case is assigned to a "Medicare Hearing Officer."

b. Some MACs are using the reconsideration process to allow providers

to explain what went wrong and rescinding
revocations. . . .

4. These letters are devastating for the individual and groups that receive them. They ease receiving medicare payments until the CAP or reconsideration process is completed and generally speaking they are so unsure about what to do with Medicare patients that they hold off scheduling medicare patients until the process is sorted out. The practitioners are subject to a punitive process in which the punishment far exceeds the crime and the patients are also punished because the process interferes with their relationship with their healthcare provider.