PUBLICATION

Understanding Medicare Corrective Action Plans

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For Medicare enrollees denied enrollment or current providers or suppliers that had billing privileges revoked, CMS established the option to file a Corrective Action Plan (CAP). Filing a CAP provides the opportunity to "correct" the deficiencies that resulted in the denial or revocation.

In providing this procedural option, it was CMS' intent to expedite the decision-making process and facilitate a more timely determination. The CAP is not a "final" determination so there is no appeal to an unfavorable decision on the CAP.

Although contractors have discretion to require the use of a standardized CAP form, most contractors have not developed such a form. There are, however, specific procedural requirements to follow when submitting a CAP:

- Must be submitted within 30 days from the date of the notice of the revocation.
- Must be in form of a letter and provide verifiable evidence that the provider or supplier is in compliance with Medicare requirements.
- Must be signed and dated by the individual enrollee, the authorized or delegated official for an entity, or a legal representative.
- May be submitted by fax.

By policy, CMS instructed its contractors not to accept a CAP when the basis for a billing privilege revocation is 42 C.F.R. § 424.535(a)(2) (exclusions and debarments); 42 C.F.R. § 424.535(a)(3) (certain felony convictions); and, 42 C.F.R. § 424.535(a)(5) (failed site verification visit). CMS determined that since there is no way to correct a deficiency of this nature, the CAP process is not an available mechanism to remedy the situation. Appeal rights remain, however, despite the inability to submit a CAP.

CMS also set certain guidelines that its Medicare contractors are to follow when reviewing a CAP:

- If the basis for denying the enrollment or revoking billing privileges was the failure of the provider or supplier to submit information to the contractor and that information is not included in the CAP submission, the contractor is to issue one development letter to obtain the information before making a final determination on the CAP.
- The Cap decision is to be issued within 60-days.

Since the processing of the CAPdoes nottoll the filing deadline for the appeal, it is important to track and not miss the deadline for the submission of the Request for Reconsideration. Providers and suppliers do have the option of submitting the Request for Reconsideration at the same time the CAP is filed. When that occurs, the following process is to be used:

- The CAP is to be processed first and the determination issued.
- If the CAP decision is not favorable, then the Reconsideration is to be processed by a Hearing Officer who was not involved in the initial determinationorthe CAP decision.

- If the CAP decision is favorable, the provider or supplier will be notified and asked to withdraw the reconsideration request.

In situations when the enrollment denial or revocation of billing privileges was not warranted, it is important that the CAP provide objective evidence demonstrating compliance with the enrollment rules. This requires not only a thorough knowledge of the enrollment requirements, but may also require detailed information regarding past enrollment application filings.