

# Avoiding the Medicare (and/or Medicaid) Death Penalty

Health Law Webinar

June 10, 2026

**Fredrikson**

The logo for Fredrikson, featuring the name "Fredrikson" in a bold, black, sans-serif font. A red horizontal bar is positioned below the "Fred" portion of the name, extending to the right.









# Why Now?

- Increasing program integrity efforts by CMS and State Medicaid programs.
- Aggressive and overbroad enforcement.
- Increased affiliation and ownership scrutiny.
- Severe penalties/consequences.

# Agenda

- Terminology.
- Story Hour.
- Regulatory Basis for Revocation and Deactivation.
- Practical Effects.
- Revalidation.
- Rebuttals and Appeals.

# Terminology

- Deactivation.
- Revocation.
- Termination.
- Disenrollment.
- “855”.
- PECOS.

# Minnesota

- Of the 5,583 high-risk providers required to revalidate:
  - 2,061 were revalidated and are continuing to provide Medicaid services without interruption.
  - 3,411 were notified they will be disenrolled:
    - 2,491 were due to submissions of incomplete paperwork and documentation.
    - 916 were due to failed verification at site visits.
    - 4 were due to failed background study.
  - 111 were removed from review at this time because they are no longer providing a high-risk service.
  - 59 were referred to the department's Office of Inspector General for further review.

# Stories to Scare You Straight

# Story Hour

- Bored by the Board.
- Missing Medical Director.
- Identificationless inspector.
- Revalidation debacles.
  - Failure to respond to something you never receive.
- Unreported deaths.
- Background study snafus.



# Revocation vs. Deactivation

Revocation: 42 CFR 424.535

- Termination of Medicare billing privileges and provider agreement.
- Appeal rights.
- Re-enrollment (following any period where barred).
- May affect status in state Medicaid program.

Deactivation: 42 CFR 424.540

- Billing privileges suspended.
- Participation remains intact.
- Lifted after submission of updated information.
- Results in billing gap.

# Deactivation Grounds

## § 424.540 Deactivation of Medicare billing privileges.

(a) **Reasons for deactivation.** CMS may deactivate the Medicare billing privileges of a provider or supplier for any of the following reasons:

- (1) The provider or supplier does not submit any Medicare claims for 6 consecutive calendar months. The 6 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 6th month without a submitted claim.
- (2) The provider or supplier does not report a change to the information supplied on the enrollment application within the applicable time period required under this title.
- (3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.
- (4) The provider or supplier is not in compliance with all enrollment requirements in this title.
- (5) The provider's or supplier's practice location is non-operational or otherwise invalid.
- (6) The provider or supplier is deceased.
- (7) The provider or supplier is voluntarily withdrawing from Medicare.
- (8) The provider is the seller in an HHA, hospice, or DMEPOS supplier change of ownership under § 424.550(b)(1).

# Reactivation

## (b) **Reactivation of billing privileges.**

(1) In order for a deactivated provider or supplier to reactivate its Medicare billing privileges, the provider or supplier must recertify that its enrollment information currently on file with Medicare is correct, furnish any missing information as appropriate, and be in compliance with all applicable enrollment requirements in this title.

(2) Notwithstanding paragraph (b)(1) of this section, CMS may, for any reason, require a deactivated provider or supplier to, as a prerequisite for reactivating its billing privileges, submit a complete Form CMS-855 application.

(3) Except as provided in paragraph (b)(3)(i) of this section, reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the State survey agency or the establishment of a new provider agreement.

(i) An HHA whose Medicare billing privileges are deactivated under the provisions found at paragraph (a) of this section must obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privileges can be reactivated.

\*\*\*\*

(c) **Effect of deactivation.** The deactivation of Medicare billing privileges does not have any effect on a provider's or supplier's participation agreement or any conditions of participation.

# Effective Dates for Reactivation

## (d) *Effective dates.*

(1)

(i) Except as provided in paragraph (d)(1)(ii) of this section, the effective date of a deactivation is the date on which the deactivation is imposed under this section.

(ii) A retroactive deactivation effective date (based on the date that the provider's or supplier's action or non-compliance occurred or commenced (as applicable)) may be imposed in the following instances:

(A) For the deactivation reasons in paragraphs (a)(2) through (4) of this section, the effective date is the date on which the provider or supplier became non-compliant.

(B) For the deactivation reason in paragraph (a)(5) of this section, the effective date is the date on which the provider's or supplier's practice location became non-operational or otherwise invalid.

(C) For the deactivation reason in paragraph (a)(6) of this section, the effective date is the date of death of the provider or supplier.

(D) For the deactivation reason in paragraph (a)(7) of this section, the effective date is the date on which the provider or supplier voluntarily withdrew from Medicare.

(E) For the deactivation reason in paragraph (a)(8) of this section, the effective date is the date of the sale.

(2) The effective date of a reactivation of billing privileges under this section is the date on which the Medicare contractor received the provider's or supplier's reactivation submission that was processed to approval by the Medicare contractor.

# Grounds for Revocation

- CMS may “revoke” billing privileges for the following reasons:
  - **“Noncompliance” with enrollment requirements or the enrollment application.**
  - Exclusion of provider/supplier or owner, managing employee, authorized or delegated official, medical director, supervising physician or other healthcare personnel of provider/supplier.
  - Certain felonies.
  - Certifying as “true” false or misleading information on the enrollment application.
  - Failing an on-site review.
  - Misuse of billing number.
  - Abuse of billing privileges.
  - Failure to report a final adverse action or change in practice location within 30 days.

# Grounds for Revocation

- Failure to document or provide CMS access to documentation.
- Failure of an HHA to provide documentation supporting initial reserve operating funds requirement.
- Termination from participation in a State Medicaid program.
- Improper prescribing practices.
- FCA judgement.
- Debt referred to the United States Department of Treasury.
- Revocation under different name, numerical identifier or business identity.

# Grounds for Revocation

- Affiliation that poses an undue risk.
- Billing from non-compliant locations.
- Abusive ordering, certifying, referring, or prescribing of Part A or B services, items or drugs.
- Action by a state board, independent review organization or other government body related to improper professional conduct that led to patient harm.
- Non-compliance with specific standards by an IDTF, DMEPOS suppliant, OTP, or Medicare diabetes prevention program.

# Revocation of billing privileges

- Once CMS has revoked billing privileges, the provider/supplier is barred from re-enrollment for at least 1 year\* and no longer than 10 years, based on the severity of the non-compliance.
- Upon re-enrollment, must submit a new application and be resurveyed and recertified, if applicable.

\*Does not apply if the revocation is based upon a failure to respond to revalidation or requests for information.

# Practical Effects

- Revocation

- Re-enrollment bar

- CMS Preclusion List

- Deactivation

- Payment prohibition. (“A provider or supplier may not receive payment for services or items furnished while deactivated under this section.”)

# Recourse

- Deactivation → Rebuttal Only.
  - Provider or supplier has 15 calendar days from the date of the written notice to submit a rebuttal to CMS as permitted under § 424.545(b).
  - Decision is not appealable.
- Revocation → Appeal.
  - 60 days to appeal.
  - If the revocation was due to adverse activity (sanction, exclusion, or felony) against the provider's or supplier's owner, managing employee, etc., the revocation may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that party within 15 days of the revocation notification.

# Revalidation Requirements

- A request by CMS that a provider or supplier recertify the accuracy of enrollment information. **§ 424.515**
- Routine revalidation = 5 year cycle.
- Off cycle revalidations.
  - May be triggered by random checks, indications of national or local fraud problems, complaints or other reasons.
  - May be accompanied by site visits.

# Unsure About Revalidation?!

- CHECK!
- Medicare maintains a “Medicare Revalidation List”
  - The Revalidation Due Date List dataset contains revalidation due dates for Medicare providers who are due to revalidate in the following six months. If a provider's due date does not fall within the ensuing six months, the due date is marked 'TBD'.
  - <https://data.cms.gov/tools/medicare-revalidation-list>

# 855 Issues – Keeping Up to Date

- Forms matter.
- Penalties for non-compliance with enrollment and claims requirements.
- Medicare enrollment forms (855A and 855B).
- Reporting requirements and timeframes.
- Pitfalls of Medicare claim forms.
- Responding to written inquiries from the government.

# How to Get Through The Minefield

- First step is understanding when and how to use the Medicare enrollment forms.
- **855A** – Institutional Providers.
  - E.g., hospitals, CORFs, ESRD facilities, HHAs, RHCs, SNFs.
- **855B** – Clinics/group practices and other suppliers.
  - E.g., clinics, ASCs, clinical labs, IDTFs, portable x-ray.

# When to use the 855s or Update PECOS

- Events triggering submission of the 855A or 855B
  - New enrollment
  - Enrolling in another MAC's jurisdiction
  - Reactivation of billing privileges
  - Voluntary termination of billing privileges (not opting out)
  - Revalidation
  - Ownership interests/management control changes
  - Change in practice location
  - Final adverse action
  - Other changes of information
  - CHOWs

# 855 Hint No. 1

- Use the chart in Section 1 to determine which sections of the 855 you must complete. This will help to ensure you don't miss a section and delay the process.
- Read the entire 855 form at least once to familiarize yourself with its content.

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**SECTION 1: BASIC INFORMATION**

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**A. REASON FOR SUBMITTING THIS APPLICATION**

Check one box and complete the required sections of this application as indicated.

<input type="checkbox"/> You are a new enrollee in Medicare	Complete all applicable sections <b>Ambulance suppliers</b> must complete <b>Attachment 1</b> <b>IDTF suppliers</b> must complete <b>Attachment 2</b> <b>OTPs</b> must complete <b>Attachment 3</b>
<input type="checkbox"/> You are solely enrolling in Medicare to participate in Medicaid or another health care program and will not bill Medicare	Complete all applicable sections
<input type="checkbox"/> You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable sections <b>Ambulance suppliers</b> must complete <b>Attachment 1</b> <b>IDTF suppliers</b> must complete <b>Attachment 2</b> <b>OTPs</b> must complete <b>Attachment 3</b>
<input type="checkbox"/> You are revalidating your Medicare enrollment	Complete all applicable sections <b>Ambulance suppliers</b> must complete <b>Attachment 1</b> <b>IDTF suppliers</b> must complete <b>Attachment 2</b> <b>OTPs</b> must complete <b>Attachment 3</b>
<input type="checkbox"/> You are reactivating your Medicare enrollment	Complete all applicable sections <b>Ambulance suppliers</b> must complete <b>Attachment 1</b> <b>IDTF suppliers</b> must complete <b>Attachment 2</b> <b>OTPs</b> must complete <b>Attachment 3</b>
<input type="checkbox"/> You are changing your Medicare information	Go to section 1B below
<input type="checkbox"/> You are voluntarily terminating your Medicare enrollment Effective date of termination (mm/dd/yyyy): <input type="text"/>  Medicare Identification Number: <input type="text"/>	Section 1, 2A1, 2A3 (optional), 4B (optional), 13 (optional), and 15

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**SECTION 1: BASIC INFORMATION (Continued)**

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**B. WHAT INFORMATION IS CHANGING?**

Check all that apply and complete the required sections.

**NOTE:** When reporting ANY information, sections **1, 2A1, 3, and 15** MUST always be completed in addition to the information that is changing within the required section.

Changing Information	Required Sections
<input type="checkbox"/> Business Identifying Information	<b>1, 2A1, 3, 12, 13 (optional)</b> and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Final Adverse Legal Actions	<b>1, 2A1, 3, 12, 13 (optional)</b> and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Medical Specialty Information	<b>1, 2A, 2B, 3, 4, 12, 13 (optional)</b> , and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Supplier Specific Information	<b>1, 2A1, 2A2-2A4, 2B-2F (as applicable), 3, 12,13 (optional)</b> , and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Reassignment of Benefits Information	<b>1, 2A1, 4H, 13 (optional)</b> and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Practice Location Information	<b>1, 2A1, 4A, 13 (optional)</b> and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Change of Ownership (Portable X-Ray Suppliers, Ambulatory Surgical Centers and Opioid Treatment Programs Only)	<b>Complete all sections and provide a copy of the sales agreement</b>
<input type="checkbox"/> Ownership Interest and/or Managing Control Information (Organizations)	<b>1, 2A1, 3, 5, 13, and 15</b> , and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Ownership Interest and/or Managing Control Information (Individuals)	<b>1, 2A1, 3, 6, 13, and 15</b> , and another <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Managing Employee Information	<b>1, 2A1, 3, 6, 12, 13 (optional)</b> , and <b>15</b> and <b>6</b> for the signer if that authorized or delegated official has not been established for this supplier

# Don't Forget Reassignment

- Complete an 855R when you are
  - Adding a new reassignment
  - Terminating a current reassignment
- When adding a reassignment, both the individual practitioner and supplier must sign.
- Form can be submitted by the individual reassigning benefits or the entity to which the benefits are reassigned.

# Different MAC Jurisdiction

- Even if you are already enrolled in Medicare with a particular tax ID, you must complete a new 855 if you establish a practice location in a different MAC's jurisdiction.
- If you are a hospital or hospital department that is enrolling with a MAC to bill for Part B services, you must complete a new 855B application.

# Reactivation and Voluntary Termination

- Reactivation
  - If you have been deactivated for any reason other than non-submission of a claim for 12 months, you must submit a new enrollment application.
  - In general, not necessary to undergo new survey or certification by state survey agency.
- Voluntary termination
  - Ceasing operations or no longer seeing Medicare patients.
  - Opting out is a different process.

# Changes of Ownership vs. Changes of Information

# Ownership Interest and Managing Control Information

- Both providers and suppliers must report information about all organizations and individuals that have 5 percent or more (direct or indirect) ownership interest in, and/or managing control of, the provider/supplier.
- This is different than a “CHOW transaction” (CHOWS are complex).
- Must report changes within 30 days.
- What is a managing employee?!

# Managing Employee

All managing employees of the provider must be reported in this section. The term “managing employee” includes but is not limited to, a general manager, business manager, administrator, director, medical director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the provider, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the provider.

# Ownership/Managing Control Information (Organizations)

- Direct vs. indirect ownership.
  - Ambulance company is 100% owned by Company A. Company A is a direct owner of the supplier. Company B owns 100% of Company A. Company B is considered an indirect owner. Both must be reported on the 855.
- All partners (general and limited) of a partnership must be reported.

# Ownership/Managing Control Information (Organizations)

- Any organization that exercises **operational or managerial control** over the provider/supplier, or conducts the **day-to-day operations** of the provider, is a managing organization and must be reported.
- No ownership interest necessary.
- E.g., management services organization under contract with the provider/supplier to furnish management services for the business.

# Updates/Changes

- Practitioners and practitioner organizations:
  - Report within 30 days:
    - A change of ownership;
    - Any adverse legal action; or
    - A change, addition, or deletion of a practice location.
  - Report within 90 days changes to
    - Managing employees.
    - Authorized and delegated officials.
    - If a corporation (profit or nonprofit), officers and directors.

# Updates/Changes

- All other providers and suppliers:
  - Report within 30 days:
    - Change of ownership or control (including changes in authorized official(s) or delegated official(s))
    - An adverse legal action
    - A change, addition, or deletion of a practice location.
  - All other changes to enrollment must be reported within 90 days.
  - Within 30 days of any revocation or suspension of a Federal or State license or certification including Federal Aviation Administration certifications, an air ambulance supplier must report a revocation or suspension of its license or certification to the applicable Medicare contractor.

# Change In Practice Location

- Providers and suppliers must report all practice locations within the MAC's jurisdiction.
- Practice locations within a different MAC jurisdiction must enroll separately.
- Special rules/sections for mobile facilities and portable units.

# Final Adverse Actions

- Official regulatory definition
  - Revocation of Medicare billing privileges.
  - Suspension or revocation of a license to provide health care by any State licensing authority.
  - Revocation or suspension by an accreditation organization.
  - Conviction of certain Federal or State felony offenses within the 10 years preceding enrollment, revalidation or re-enrollment.
  - An exclusion or debarment from participation in a Federal or State health care program.

# Final Adverse Actions

- Must report regardless of whether records were expunged or appeals are pending.
- Must report actions against the provider/supplier entity AND actions against the organizational and individual owners, the managing employees, authorized and delegated officials and officers and directors (for corporations).

# Overpayment Liability

**§ 424.565 Overpayment.** A physician or nonphysician practitioner organization, physician or nonphysician practitioner that does not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart is assessed an overpayment back to the date of the final adverse action or change in practice location. Overpayments are processed in accordance with part 405 subpart C of this chapter.

# CHOW

- In general, this is a transaction where a Medicare **provider** gets purchased or leased by another entity.
- The provider agreement is automatically assigned to the new owner.
- The buyer must submit an 855 as a new enrollment. The seller also must complete an 855 indicating the CHOW.

# CHOW

- Regulatory definition (489.18)
  - **Corporation:** merger of provider into another corporation or consolidation of two or more corporations.
    - Does not include stock transfers. Stock transfers are changes of ownership.
  - **Partnership:** removal, addition or substitution of a partner.
  - **Lease:** leasing of all or part of a provider facility.
  - **Unincorporated sole proprietorship:** transfer of title and property to another party.

# Other changes in information

- Must report all changes within 90 days.
- Catch-all category
  - Legal business name or assumed names
  - Address/contact information
  - State license or certification information
  - Accreditation
  - Base of operations for mobile or portable providers/suppliers
  - Medical record storage facilities
  - Vehicle information

# Other changes in information

- Payment addresses
- Chain home office information
- Billing agency information
- Authorized or delegated officials (providers/suppliers that are not practitioners or practitioner organizations must report w/in 30 days)
- Ambulance service suppliers – geographic area, paramedics, vehicles
- IDTFs – supervising and interpreting physicians, CPT and HCPCS codes, techs
- HHAs – nursing registries, financial documentation

# Presenters



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