

Medicare Program Integrity Manual

Chapter 15 - Medicare Enrollment

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15.1 – Introduction to Provider Enrollment

(Rev. 347, Issued: 07-15-10, Effective: 07-30-10, Implementation: 07-30-10))

This chapter specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program. These procedures apply to A/B MACs (A & B) and the National Supplier Clearinghouse (NSC), unless contract specifications state otherwise.

No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare fee-for-service contractor.

15.1.2 – Medicare Enrollment Application (Form CMS-855)

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

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.

The 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 supplier organizations (e.g., ambulance companies) 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., hospitals) that will furnish Medicare Part A services to beneficiaries.

- 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.
- CMS – 20134– This application should be completed by any supplier organizations that will furnish and bill Medicare Part B for the Medicare Diabetes Prevention Program services furnished to Medicare beneficiaries.

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-855, 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).
- Any 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 contact the State agency for any State-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.

15.1.3 – Medicare Contractor Duties

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The contractor shall adhere to all of the instructions in this chapter 15 (hereafter generally referred to as “this chapter”) and all other CMS provider enrollment directives (e.g., Technical Direction letters). The contractor shall also assign the appropriate number of staff to the

Medicare enrollment function to ensure that all such instructions and directives - including application and opt-out affidavit processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding the Provider Enrollment, Chain and Ownership System (PECOS).

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS
- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations) through PECOS
- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS
- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application
- Participate in user acceptance testing for each PECOS release
- Attend scheduled PECOS training when requested

- Report PECOS validation and production processing problems through the designated tracking system for each system release
- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855 or CMS-20134 applications and the appropriate entry of data into PECOS.

C. Validation and Processing

The contractor shall:

- Review the application or opt-out affidavit to determine whether it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate enrollment application or affidavit. Unless stated otherwise in this chapter or in another CMS directive, the provider must complete all required data elements on the Form CMS-855 or CMS-20134 via the application itself.
- Unless stated otherwise in this chapter or in another CMS directive, verify and validate all information collected on the enrollment application or opt-out affidavit, provided that a data source is available.
- Coordinate with State survey/certification agencies and regional offices (ROs), as needed
- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes in accordance with the instructions in this chapter and all other CMS directives.
- Confirm that the applicant, all individuals and entities listed on the application, eligible practitioner on an opt-out affidavit, and any names or entities ascertained through other sources, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management (as excluded individuals and entities may not enroll with Medicare and excluded eligible practitioners may opt-out, but cannot order and refer items and services).

D. Customer Service

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., emails, letters, telephone calls) within 30 business days of receipt.

15.2 – Provider and Supplier Business Structures (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

This section explains the legalities of various types of business organizations that may enroll,

including sole proprietorships. Note that the provider's organizational structure can have a significant impact on the type of information it must furnish on the Form CMS-855 or CMS-20134.

Business organizations are generally governed by State law. Thus, State X may have slightly different rules than State Y regarding certain entities. (In fact, X may permit the creation of certain types of legal entities that Y does not.) The discussion below gives only a broad overview of the principal types of business entities and does not take into account different State nuances.

Since CMS issues a 1099 based on an enrolled entity's business structure, providers and suppliers should consult with their accountant or legal advisor to ensure that they are establishing the correct business structure.

A. Sole Proprietorships

A business is a sole proprietorship if it meets all of the following criteria:

- It files a Schedule C (1040) with the IRS (this form reports the business's profits/losses);
- One person owns all of the business's assets; and
- It is not incorporated.

A sole proprietorship is not a corporation. Suppose a physician operates his/her business as a home health agency. If he/she incorporates his/her business, the business becomes a corporation (even though the physician is the only stockholder). Thus, the frequently used term "unincorporated sole proprietorship" is a misnomer because sole proprietorships by definition are unincorporated. In addition, merely because the sole proprietor hires employees does not mean that the business is no longer a sole proprietorship. Assume that W is a sole proprietor and he hires X, Y, and Z as employees. W's business is still a sole proprietorship because he remains the 100% owner of the business. If, however, W had sold parts of his sole proprietorship to X, Y, and Z, the business would no longer be a sole proprietorship, as there is now more than one owner.

Note that professional associations (PAs) are generally not considered to be sole proprietorships; the PA designation is typically used in States that do not allow individuals to incorporate and form professional corporations. The PA will have its own Employer Identification Number and is considered, like a professional corporation, to be a legal entity that is separate and distinct from the individual.

B. Partnerships

A partnership is an association of two or more persons/entities who carry on a business for profit. Each partner in a partnership is an owner. If A and B form the "Y Partnership" and each contributes \$50,000 to start up the business, each partner owns one-half of Y.

In several respects, a partnership is the opposite of a corporation:

- Each partner is liable for all the debts of the partnership. Using the example above, suppose the Y Partnership breached a contract it had with X, who now sues for \$10,000. Since each partner is liable for all debts, X can collect the entire \$10,000 from A, or from B, or \$5,000 from each, etc. This is because, unlike a corporation, a partnership is not really a separate and distinct entity from its partners/owners; the partners are the partnership. If Y had been a corporation, the owners (A and B) would likely have been shielded from liability.
- There is no “double taxation” with partnerships. The partnership itself does not pay taxes, although each partner pays taxes on any income he/she earns from the business.
- Unlike a corporation, a partnership generally does not file papers with the State upon its creation (i.e., it does not file the equivalent of articles of incorporation). Instead, a partnership has a “partnership agreement,” which amounts to a contract between the partners outlining duties, responsibilities, powers, etc.
- Each partner has the right to participate in running the business’s day-to-day operations, unless the partnership agreement dictates otherwise.

An alternative type of partnership is a limited partnership (as opposed to a “general partnership,” described above). While possessing many of the characteristics of a general partnership, there are some key differences. First, a limited partnership (LP) must file formal documents with the State. Second, a LP has two types of partners –general and limited. The general partner(s) runs the business, yet is personally responsible for all of the LP’s debts. Conversely, the limited partner(s) has limited liability yet cannot participate in the management of the business.

C. Limited Liability Companies (LLC)

A limited liability company (LLC) is a legal entity that is neither a partnership nor a corporation, but has characteristics of both. Its owners have limited liability (just like stockholders in a corporation). Also, the LLC does not pay Federal taxes (similar to a partnership), although its owners – usually referred to as “members” - must pay taxes on any dividends they earn. An LLC thus contains the best attributes of corporations and partnerships; LLCs are therefore rapidly gaining in popularity.

An LLC should not be confused with a limited liability corporation, which is a type of corporation in some States. A limited liability company is not a corporation or partnership, but a distinct legal entity created and regulated by special State statutes.

Note that certain Form CMS-855 or CMS-20134 information is required of different entities. The primary example of this is in section 6. If the provider is a corporation, it must list its officers and directors on the form. Partnerships and LLCs, on the other hand, do not have officers or directors and thus need not list them.

D. Joint Ventures

A joint venture is when two or more persons/entities combine efforts in a business enterprise and agree to share profits and losses. It is very similar to a partnership, and is treated as a partnership for tax purposes. The key difference is that a partnership is an ongoing business, while a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, can be classified as a “temporary partnership.”

E. Corporations

A corporation is an entity that is separate and distinct from its owners (called stockholders, or shareholders). To form a corporation, various documents – such as articles of incorporation – must be filed with the State in which the business will incorporate. The key elements of a corporation are:

- **Limited Liability** – This is the main reason for a business’s decision to operate as a corporation. Suppose Corporation X has ten stockholders, each owning 10% of the business. X breached a contract it had with Company Y, which now wants to sue X’s owners. Unfortunately for Y, it can generally only sue X itself; it cannot sue X’s shareholders. The corporation’s owners are essentially shielded from liability for the actions of the corporation because, as stated above, a corporation is separate and distinct from its owners.

Despite the concept of limited liability, there may be instances where a corporation’s owners/stockholders can be held personally liable for the corporation’s debts. This is known as “piercing the corporate veil,” whereby one tries to get past the brick wall of the corporation in order to collect from the owners behind that wall. However, piercing the corporate veil is a difficult thing to do and many courts are unwilling to allow it, meaning that plaintiffs can only collect from the corporation itself.

- **“Double” Taxation** – This is the principal reason for a business’s decision not to be a corporation. “Double” taxation means that: (1) the corporation itself must pay taxes, AND (2) each shareholder must pay taxes on any dividends he/she receives from the business.

- **Board of Directors** – Most corporations are run by a governing body, typically called a Board of Directors.

Two special types of corporations that contractors may encounter are:

- **“Professional Corporation” or “PC.”** In general, a PC (1) is organized for the sole purpose of rendering professional services (such as medical or legal), and (2) all stockholders in a PC must be licensed to render such services. Thus, if A, B and C want to form a physician practice (each is a 1/3 stockholder) and only A is a medical professional, a PC probably cannot be formed (depending, of course, on what the applicable State PC statute says). In addition, the title of a PC will usually end in “PC,” “PA” (Professional Association) or “Chartered.”

- **“Close” Corporation (or “closely-held” corporation)** – This is a type of corporation with a very limited number of stockholders. Unlike a “regular” corporation, the entity’s board of

directors generally does not run the business; rather, the shareholders do. The stock is typically not sold to outsiders.

Although PCs and close corporations (CCs) are considered “corporations” for enrollment purposes, State laws governing these entities are often different from those that govern “regular” corporations (i.e., States have separate statutes for “regular” corporations and for PCs/CCs.) In many cases, an entity must specifically elect to be a PC or CC when filing its paperwork with the State.

F. Non-Profit Organizations

The term “non-profit organization” (NPO) is misleading. It does not signify an organization that is forbidden to make a profit. Rather, it means that all of the organization’s profits are put back into the entity to promote its goals, which are usually political, social, religious, or charitable in nature. In other words, an NPO is not organized primarily for profit, but instead to further some other goal. An entity can acquire NPO status by obtaining a 501(c)(3) certification from the IRS (meaning it is tax-exempt) or by acquiring such status from the State in which it is located.

The NPO status is important for enrollment purposes because NPOs generally do not have owners. Thus, a NPO need not list any owners in sections 5 or 6 of the Form CMS-855 or CMS-20134.

G. Government-Owned Entities

For purposes of enrollment, a government-owned entity (GOE) exists when a particular government body (e.g., Federal, State, city or county agency) will be legally and financially responsible for Medicare payments received. For example, suppose Smith County operates Hospital X. Medicare overpaid X \$100,000 last year. If Smith County is the party responsible for reimbursing Medicare this amount, X is considered a government-owned entity.

Note that:

- GOEs do not have “owners.” Thus, section 5 of the Form CMS-855 or CMS-20134 need only contain the name of the government body in question. Using our example above, this would be Smith County.
- For section 6 of the Form CMS-855 or CMS-20134, the only people that must be listed are “managing employees.” This is because GOEs do not have corporate officers or directors.

The provider must submit a letter from the government body certifying that the government entity will be responsible for any Medicare payments.

15.3 – National Provider Identifier (NPI) **(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

A. Submission of NPI

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the Form CMS-855 or CMS-20134. The provider need not submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES) unless the contractor requests it to do so. Similarly, if the provider obtained its NPI via the Electronic File Interchange (EFI) mechanism, the provider need not submit a copy of the notification it received from its EFI Organization (EFIO) unless the contractor requests it to do so. (The notification from the EFIO will be in the form of a letter or e-mail.) If the contractor requests paper documentation of a provider's NPI, the contractor may accept a copy of the provider's NPI Registry's Details Page in lieu of a copy of the NPI notification. The Details Page contains more information than is contained on the NPI notification, and providers may be able to furnish NPI Registry Details Pages more quickly than copies of their NPI notifications.

The aforementioned requirement to list all applicable NPIs on the Form CMS-855 or CMS-20134 applies to all applications. (The only exceptions to this involve voluntary terminations, deactivations, deceased providers, and change of ownership (CHOW) applications submitted by the old owner. NPIs are not required in these instances.) Thus, for instance, if a reassignment package is submitted, the NPIs for all involved individuals and entities must be furnished; even if an individual is reassigning benefits to an enrolled group, the group's NPI must be furnished on the Form CMS-855R.

NOTE: The National Supplier Clearinghouse (NSC) shall obtain the NPPES notification from the applicant or verify the NPI and the Type of NPI (i.e., Type 1 or Type 2) through the NPI Registry.

B. Additional NPI Information

If a provider submits an NPI notice to the contractor as a stand-alone document (i.e., no Form CMS-855 or CMS-20134 was submitted), the contractor shall not create a logging & tracking (L & T) record in PECOS for the purpose of entering the NPI. The contractor shall simply place the notice in the provider file. The contractor shall only enter NPI data into PECOS that is submitted in conjunction with a Form CMS-855 or CMS-20134 (e.g., initial, change request). Thus, if a provider submits a Form CMS-855 or CMS-20134 change of information that only reports the provider's newly assigned NPI, or reports multiple NPIs that need to be associated with a single Medicare identification number, the contractor may treat this as a change request and enter the data into PECOS.

C. Subparts - General

The contractor shall review and become familiar with the principles outlined in the "Medicare Expectations Subpart Paper," the text of which follows below. It was originally issued in January 2006 and has since been slightly updated to reflect certain changes in Medicare terminology.

CMS encourages all providers to obtain NPIs in a manner similar to how they receive CMS

Certification Numbers (CCNs) (i.e., a “one-to-one relationship”). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider and the branch will typically receive separate (albeit very similar) CCNs. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each CCN.

D. Medicare Subparts Paper - Text

MEDICARE EXPECTATIONS ON DETERMINATION OF SUBPARTS BY MEDICARE ORGANIZATION HEALTH CARE PROVIDERS WHO ARE COVERED ENTITIES UNDER HIPAA

Purpose of this Paper

Medicare assigns unique identification numbers to its enrolled health care providers. They are used to identify the enrolled health care providers in the HIPAA standard transactions that they conduct with Medicare (such as electronic claims, remittance advices, eligibility inquiries/responses, claim status inquiries/responses, and coordination of benefits) and in cost reports and other non-standard transactions.

This paper is a reference for Medicare contractors. It reflects the Medicare program’s expectations on how its enrolled organization health care providers that are covered entities under HIPAA¹ will determine subparts and obtain NPIs for themselves and any subparts. These expectations may change over time to correspond with any changes in Medicare statutes, regulations, or policies that affect Medicare provider enrollment.

These expectations are based on the NPI Final Rule, on statutory and regulatory requirements with which Medicare must comply, and on policies that are documented in Medicare operating manuals and other directives. These Medicare statutes, regulations and policies pertain to conditions for provider participation in Medicare, enrollment of health care providers in Medicare and assignment of identification numbers for billing and other purposes, submission of cost reports, calculation of payment amounts, and the reimbursement of enrolled providers for services furnished to Medicare beneficiaries.

This paper categorizes Medicare’s enrolled organization health care providers as follows:

- Certified providers and certified suppliers
- Supplier groups and supplier organizations
- Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

¹ Covered entities under HIPAA are health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a health transaction for which the Secretary of HHS has adopted a standard (referred to in this paper as HIPAA standard transactions). Most Medicare Organization health care providers send electronic claims to Medicare (they are HIPAA standard transactions), making them covered health care providers (covered entities).

This paper is not intended to serve as official HHS guidance to the industry in determining subparts for any covered health care providers other than those that are organizations and are enrolled in the Medicare program. This paper does not address health care providers who are enrolled in Medicare as individual practitioners. These practitioners are Individuals (such as physicians, physician assistants, nurse practitioners, and others, including health care providers who are sole proprietors). In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI. As Individuals, these health care providers cannot be subparts and cannot designate subparts. A sole proprietorship is a form of business in which one person owns all of the assets of the business and the sole proprietor is solely liable for all of the debts of the business. There is no difference between a sole proprietor and a sole proprietorship. In terms of NPI assignment, a sole proprietor/sole proprietorship is an Entity Type 1 (Individual) and is eligible for a single NPI. As an Individual, a sole proprietor/sole proprietorship cannot have subparts and cannot designate subparts.

Discussion of Subparts in the NPI Final Rule and its Applicability to Enrolled Medicare Organization Health Care Providers

The NPI Final Rule adopted the National Provider Identifier (NPI) as the standard unique health identifier for health care providers for use in HIPAA standard transactions. On or before May 23, 2007, all HIPAA covered entities (except small health plans), to include enrolled Medicare providers and suppliers that are covered entities, were required to obtain NPIs and to use their NPIs to identify themselves as “health care providers” in the HIPAA standard transactions that they conduct with Medicare and other covered entities. Covered organization health care providers are responsible for determining if they have “subparts” that need to have NPIs. If such subparts exist, the covered organization health care provider must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

The NPI Final Rule contains guidance for covered organization health care providers in determining subparts. Subpart determination is necessary to ensure that entities within a covered organization health care provider that need to be uniquely identified in HIPAA standard transactions obtain NPIs for that purpose.

The following statements apply to **all** entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR § 160.103.

The following statements may relate to some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.

- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

- Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. Medicare covered organization health care providers must take any such statutes or regulations into account to ensure that, if Medicare providers are uniquely identified now by using Medicare identifiers in HIPAA standard transactions, they obtain NPIs in order to ensure they can continue to be uniquely identified. Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions (for organizations, these could be CCNs, Provider Transaction Access Numbers (PTANs), or NSC Numbers—known as legacy identifiers or legacy numbers) to NPIs. This makes it necessary that Medicare organization health care providers obtain NPIs because the NPIs have replaced the identifiers currently in use in standard transactions with Medicare and with all other health plans. In addition, Medicare organization health care providers must determine if they have subparts that need to be uniquely identified for Medicare purposes (for example, in HIPAA standard transactions conducted with Medicare). If that is the case, the subparts will need to have their own unique NPIs so that they can continue to be uniquely identified in those transactions.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Enrolled Medicare organization health care providers that are covered entities under HIPAA must apply for NPIs as Organizations (Entity Type 2). Organization health care providers as discussed in this paper are corporations or partnerships or other types of businesses that are considered separate from an individual by the State in which they exist. Subparts of such organization health care providers who apply for NPIs are also Organizations (Entity Type 2).

Medicare Statutes, Regulations, Manuals

The Social Security Act (sections 1814, 1815, 1819, 1834, 1861, 1865, 1866, and 1891) and Federal regulations (including those at 42 CFR 400.202, 400.203, 403.720, 405.2100, 409.100, 410.2, 412.20, 416.1, 418.1, 424, 482.1, 482.60, 482.66, 483, 484, 485, 486, 489, 491, and 493.12) establish, among other things, the Conditions for Participation for Medicare providers and set requirements by which Medicare enrolls providers, requires cost reports, calculates reimbursement, and makes payments to its providers. These Medicare statutory and regulatory requirements are further clarified in various Medicare operating manuals, such as the State Operations Manual and the Program Integrity Manual, in which requirements and policies concerning the assignment of unique identification numbers, for billing and other purposes, are stated.

Medicare Organization Providers and Subparts: Certified Providers and Certified Suppliers

² Clinical laboratory certification is handled by the Food and Drug Administration.

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to Medicare certified providers and certified suppliers for billing purposes.

Certified Providers that bill Medicare Part A (hereinafter referred to as “providers”):

- Providers apply for Medicare enrollment by completing a Form CMS-855A.
- Most providers are surveyed and certified by the States³ prior to being approved as Medicare providers.
- Providers have in effect an agreement to participate in Medicare.⁴
- Providers include, but are not limited to: skilled nursing facilities, hospitals⁵, critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.
- Providers are assigned CCNs to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.
- In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (One exception involves home health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

Certified Suppliers, which bill Medicare Part B:

- Certified suppliers apply for Medicare enrollment by completing a Form CMS-855A or CMS-855B, depending on the supplier type.
- Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.
- Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)

³ Religious non-medical health care institutions are handled differently.

⁴ Community mental health centers attest to such an agreement. Religious non-medical health care institutions are handled differently.

⁵ Hospitals bill Medicare Part B for certain types of services.

- Certified suppliers may have in effect an agreement to participate in Medicare.
- Certified suppliers are assigned CCNs for purposes of identification within Medicare processes. However, the contractors assign unique identification numbers to certain certified suppliers for billing purposes. (For CLIA labs, a CLIA number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA number may not be used to identify a clinical laboratory as a “health care provider” in HIPAA standard transactions. The CLIA number has no relation to the Medicare PTAN.)
- In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

In general, Medicare bases its enrollment of providers and certified suppliers on two main factors: (1) whether a separate State certification or survey is required, and (2) whether a separate provider or certified supplier agreement is needed. (The Taxpayer Identification Number, or TIN, is a consideration as well, though not to the degree of the two main factors.) The CMS regional offices generally make the final determinations on both of these factors; hence, Medicare provider and certified supplier enrollment policy is dictated to a significant degree by the CMS regional offices’ decisions in particular cases.

Medicare Expectations for NPI Assignments for Providers and Certified Suppliers: To help ensure that Medicare providers and certified suppliers do not experience denials of claims or delays in Medicare claims processing or reimbursement, Medicare encourages each of its enrolled providers and certified suppliers to obtain its own unique NPI. These NPIs have replaced the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports. In order for subpart determinations to mirror Medicare enrollment, each enrolled provider and certified supplier that is a covered organization health care provider should:

- Obtain its own unique NPI.
- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, a total of 11 unique NPIs should be obtained: one for the hospital, and one for each of the 10 home health agencies.

Regardless of how an enrolled provider or certified supplier that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled provider or certified supplier.

Medicare Organization Providers and Subparts:

Supplier Groups and Supplier Organizations

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to supplier groups and supplier organizations for billing purposes.

- Supplier groups and supplier organizations apply for Medicare enrollment by completing a Form CMS-855B or CMS-20134.
- Supplier groups and supplier organizations bill Medicare Part B.
- Certain supplier organizations are certified by the States, certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the contractor. These requirements vary by type of supplier organization.
- Supplier groups are primarily group practices, such as a group of physicians or other practitioners.
 - Supplier organizations include ambulance companies, mammography facilities, and independent diagnostic testing facilities (IDTFs) and Medicare Diabetes Prevention Program (MDPP) suppliers.

Medicare enrolls supplier groups/supplier organizations based on TINs. A supplier group or supplier organization may have multiple locations; however, if each location operates under the same single TIN, Medicare does not separately enroll each location. There are exceptions:

1. When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a Form CMS-855B and the IDTF would complete a Form CMS-855B. Each one would receive its own unique Medicare identification number.
2. If a separate site visit, State certification, or on-site inspection by the contractor or if FDA certification is required for each practice location of that supplier group/supplier organization.

In these above exceptions, Medicare separately enrolls each different Medicare specialty and each separately visited, certified or contractor-inspected practice location.

Medicare Expectations for NPI Assignments for Supplier Groups and Supplier

Organizations: To help ensure that Medicare supplier groups and supplier organizations do not experience delays in Medicare claims processing or reimbursement, Medicare encourages each of its enrolled supplier groups and supplier organizations to obtain its own unique NPI. These NPIs have replaced the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports. In order for subpart determinations to mirror

Medicare enrollment, each enrolled supplier group and supplier organization that is a covered organization health care provider should ensure the following:

- Obtain its own unique NPI.
- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them.

EXAMPLE: An enrolled IDTF has four different locations, and each one must be separately inspected by the contractor. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, a total of four unique NPIs should be obtained: one for each location.

Regardless of how an enrolled supplier group or supplier organization that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled supplier group or supplier organization.

Medicare Organization Providers and Subparts: DMEPOS Suppliers

Medicare regulations require that each practice location of a supplier of DMEPOS (if it has more than one) must, by law, be separately enrolled in Medicare and have its own unique Medicare identification number.

- A supplier of DMEPOS enrolls in Medicare through the National Supplier Clearinghouse (NSC) by completing a Form CMS-855S.
- Suppliers of DMEPOS bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs).
- Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies. (Any organization that sells equipment or supplies that are billed to Medicare through the DME MAC must be enrolled as a supplier of DMEPOS through the NSC. Sometimes, these are organizations that also furnish services that are covered by Medicare, such as ambulatory surgical centers. In order to be reimbursed for the DME supplies that they sell, they must separately enroll in Medicare as a supplier of DME.)

Medicare Expectations for NPI Assignments for Suppliers of DMEPOS: Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI.

Final Notes About NPIs

Enrolled organization health care providers or subparts that bill more than one Medicare contractor: An enrolled organization health care provider or subpart is expected to use a single

(the same) NPI when billing more than one Medicare contractor. For example, a physician group practice billing Contractor X and also billing Contractor Y would use a single (the same) NPI to bill both contractors.

Enrolled organization health care providers or subparts that bill more than one type of Medicare contractor: Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor that processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type of Medicare contractor. However, in certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as more than one type of provider. For example, an ambulatory surgical center enrolls in Medicare as a certified supplier and bills a Part A/B Medicare Administrative Contractor (A/B MAC). If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill a DME MAC. This ambulatory surgical center would obtain a single NPI and use it to bill the A/B MAC and the DME MAC. Medicare expects that this ambulatory surgical center would report two different Taxonomies when it applies for its NPI: (1) that of ambulatory health care facility—clinic/center--ambulatory surgical (261QA1903X) and (2) that of suppliers—durable medical equipment & medical supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization.

Enrolled organization health care providers that determine subparts for reasons unrelated to Medicare statutes, regulations or policies:

Consistent with the NPI Final Rule, covered organization health care providers designate subparts for reasons that are not necessarily related to Medicare statutes or regulations. If a Medicare organization health care provider designates as subparts entities other than those that are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, those NPIs will not identify enrolled Medicare providers. Medicare is not required to enroll them. (NPI Final Rule, page 3441: “If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls.”))

Medicare uses NPIs to identify health care providers and subparts in HIPAA standard transactions. (NPI Final Rule, page 3469: section 162.412(a): “A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider’s identifier is required.”) Medicare ensures that the NPIs it receives in HIPAA standard transactions are valid⁶. Medicare rejects HIPAA standard transactions that contain invalid NPIs. Valid NPIs, however, like the provider identifiers used today, must be “known” to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers⁷, nor is it permitted to reimburse providers that are not enrolled in the Medicare program. Medicare returns, with appropriate messages, any HIPAA standard transactions containing valid but

⁶ The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.

⁷ There may be exceptions for emergency or very unusual situations.

unrecognizable NPIs.

15.3.1 – NPI-Legacy Combinations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

If the contractor determines that a provider is having claim payment issues due solely to an incorrect NPI-Provider Transaction Access Number (PTAN) combination or NPI-CMS Certification Number (CCN) combination entered into the Provider Enrollment, Chain and Ownership System (PECOS), the contractor shall request that the provider submit the correct NPI-legacy combination via a Form CMS-855 or CMS-20134 change of information. The change request can be faxed, although the contractor shall verify the faxed signature against the provider's or authorized official's signature on file before any changes are made in PECOS.

The contractor shall not use this process to resolve any enrollment issue other than the correction of the NPI-legacy identifier combination. Moreover, the contractor shall not use this process for providers that have not submitted a complete Form CMS-855 or CMS-20134 enrollment application during or after May 2006. For instance, assume a provider first enrolled in Medicare in December 2005 and has not submitted a complete enrollment application after that date. The provider would be unable to utilize the process described in this section.

15.3.2 – NPI Punctuation

(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

PECOS and NPPES allow for the entry of punctuation and certain special characters in the provider's Legal Business Name (LBN). Examples of acceptable punctuation and special characters are ampersands, apostrophes, commas, hyphens, left and right parentheses, periods, pound signs, and quotation marks.

When punctuation or special characters are part of a provider's LBN as shown on the IRS CP-575, the punctuation or special characters should also appear in the LBN in NPPES and the LBN in PECOS. However, the contractor may use its discretion with respect to accepting a match between NPPES and PECOS if a comma or a period is the only discrepancy between the LBN in NPPES and the LBN in PECOS. The contractor should not delay processing a provider's Medicare enrollment application by requiring the provider to change its LBN in NPPES in order to conform to a discrepancy related to punctuation and/or special character.

Examples of LBN Matches and Non-Matches and Actions to Be Taken

| NPPES LBN | PECOS LBN | Exact Match |
|----------------------------|----------------------|---|
| Health Systems, Inc. | HEALTH SYSTEMS, INC. | Yes, this is an exact match. |
| Quality Care, Incorporated | Quality Care, Inc. | No, this is not an exact match (because of the abbreviation 'Inc.' in the PECOS LBN). In this case, the contractor may |

| | | |
|-------------------------------|---------------------------------|--|
| | | accept the match since both versions are an accurate match (e.g., Incorporated or Inc; Limited Liability Company or LLC; etc.) |
| Health & Rehabilitation, Inc. | Health and Rehabilitation Inc. | <p>No, this is not an exact match (because the ampersand and ‘and’ do not match).</p> <p>In this case, the contractor shall refer to the IRS CP-575. If the ampersand is displayed on the IRS CP-575, the Medicare contractor may accept the match. If the ampersand is not present and the word ‘and’ is present, the Medicare contractor shall ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575.</p> |
| Allergy & Asthma, Inc. | Allergy & Asthma, INC. | Yes, this is an exact match. Upper and lower cases do not affect a match. |
| Foot-Ankle, LLC | Foot Ankle LLC | <p>No, this is not an exact match (because the hyphen is in one LBN but not in the other).</p> <p>In this case, the contractor shall refer to the IRS CP-575. If the hyphen is displayed on the IRS CP-575, the contractor may accept the match. If the hyphen is not present, the contractor shall ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575.</p> |
| Rehab and Health, Inc. | Rehabilitation and Health, Inc. | No, this is not an exact match (because ‘Rehab’ and ‘Rehabilitation are different words). |

| | | |
|--|--|---|
| | | <p>In this case, the contractor should refer to the IRS CP-575. If the LBN ‘Rehab and Health, Inc.’ is displayed on the IRS CP-575, the contractor may accept the match. If ‘Rehabilitation and Health, Inc.’ is present, the contractor should ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575.</p> |
|--|--|---|

Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their “doing business as name” as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to read in accordance with the IRS CP-575, and (2) report its “doing business as” name in NPPES as an “Other Name” and indicate the type of other name as a “doing business as” name.

15.5 – Sections of the Forms CMS-855A, CMS-855B, and CMS-855I and CMS-20134

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background

Sections 15.5.1 through 15.5.19.7 below discuss various data elements on the Form CMS-855A, Form CMS-855B, Form CMS-855I, and Form CMS-20134. Not every data element on the forms is discussed in these sections; only those elements that warrant additional instructions are mentioned. Nonetheless, the contractor shall – unless stated otherwise in this chapter or in another CMS directive - adhere to all instructions in this chapter 15 in terms of the collection, processing, and verification of all data elements on the Form CMS-855 applications, regardless of whether the data element in question is discussed in sections 15.5.1 through 15.5.19.7.

For purposes of these sections, and unless otherwise indicated, the term “approval” includes recommendations for approval.

B. Precedence of Sections 15.7 through 15.7.1.6.2

Though the contractor shall follow the instructions in sections 15.5.1 through 15.5.19.7, any specific processing or verification instructions in sections 15.5.7 through 15.7.1.6.2 shall – unless stated otherwise in this chapter or in another CMS directive - take precedence over those in sections 15.5.1 through 15.5.19.7.

See sections 15.7.1.3.1 and 15.7.1.3.2 for information regarding “processing alternatives.”

15.5.1 - Basic Information (Section 1 of the Form CMS-855 and CMS-20134) (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless otherwise stated in this chapter or in another CMS directive, the provider may only check one reason for submittal. Suppose a supplier is changing its tax identification number via the Form CMS-855B. The supplier must submit two applications: (1) an initial Form CMS-855B as a new supplier, and (2) a Form CMS-855B voluntary termination. Both transactions cannot be reported on the same application.

A provider shall enroll as an initial applicant if it is:

- Seeking to reestablish itself in the Medicare program after reinstatement from an exclusion or debarment or after the expiration of a reenrollment bar, or
- A hospital requesting enrollment via the Form CMS-855B to bill for practitioner services for hospital departments, outpatient locations and/or hospital clinics.
- A hospital, clinic or other entity with an existing enrollment in Medicare requesting enrollment as an MDPP supplier via the Form CMS-20134 to bill for MDPP services.

15.5.2 – Identifying Information (Section 2 of the Form CMS-855 and Form CMS-20134) (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless specifically indicated otherwise, the instructions in sections 15.5.1 through 15.5.2.3 below apply to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, and the Form CMS-20134.

The instructions in section 15.5.2.4 apply only to the Form CMS-855A; the instructions in section 15.5.2.5 apply only to the Form CMS-855B; and the instructions in section 15.5.2.6 only apply to the Form CMS-855I; and the instructions in section 15.5.2.6 only apply to the Form CMS-20134.

15.5.2.1 – Licenses and Certifications, and Recognition (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The extent to which the applicant must complete the licensure or certification information in section 2 of the Form CMS-855 depends upon the provider type involved. For instance, some states may require a particular provider to be “certified” but not “licensed,” or vice versa. Additionally, applicants applying through the Form CMS-20134 are not required to have either a license or certification, but rather CDC recognition, described further in this section (see

15.5.2.1.C).

The provisions in this section 15.5.2.1 are subject to the “processing alternatives” described in sections 15.7.1.3.1 through 15.7.1.3.2 and 15.7.1.3.5 of this chapter.

A. Form CMS-855B and Form CMS-855I

The contractor shall verify that the supplier is licensed and/or certified to furnish services in:

- The state where the supplier is enrolling.
- Any other state within the contractor’s jurisdiction in which the supplier (per section 4 of the Form CMS-855) will maintain a practice location.

The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required, though business licenses needed for the applicant to operate as a health care facility or practice must be submitted. In addition, there may be instances where the supplier is not required to be licensed at all in a particular state; the contractor shall still ensure, however, that the supplier meets all applicable state and Medicare requirements.

The contractor shall also adhere to the following:

- **State Surveys:** Documents that can only be obtained after state surveys or accreditation need not be included as part of the application. (This typically occurs with ASCs and portable x-ray suppliers.) The supplier must, however, furnish those documents that can be submitted prior to the survey/accreditation.

The contractor shall include any licenses, certifications, and accreditations submitted by ASCs and portable x-ray suppliers in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO for the ASC or portable x-ray supplier, the contractor is encouraged, but not required, to contact the RO, state agency, or supplier for the applicable licensing and/or certification data and to enter it into PECOS.

- **Notarization:** If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate state agency. (A notarized copy of an original document has a stamp that says "official seal," along with the name of the notary public, the state, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the state and county in which it originated or is stored.)
- **Temporary Licenses:** If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A

temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

- **Revoked/Suspended Licenses:** If the applicant had a previously revoked or suspended license reinstated, the applicant must submit a copy of the reinstatement notice with the application.

- **Date of Enrollment** – For suppliers other than ASCs and portable x-rays, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose the supplier met all the requirements needed to enroll in Medicare (other than the submission of a Form CMS-855I) on January 1. He sends his Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1. (**NOTE:** The matter of the date of enrollment is separate from the question of the date from which the supplier may bill.)

- **License Expiration/Revocation Dates for Non-Certified Suppliers** – For expired licenses, the contractor shall enter into PECOS the day after the expiration as the expiration date. For revoked and suspended licenses, the contractor shall enter into PECOS the revocation date (not the day after) as the expiration date.

See section 15.7.5.1 of this chapter for special instructions related to periodic license reviews and certain program integrity matters.

B. Form CMS-855A

Documents that can only be obtained after state surveys or accreditation need not be included as part of the application, nor must the data be provided in section 2 of the Form CMS-855A. The provider shall, however, furnish those documents that can be submitted prior to the survey/accreditation. The contractor shall include all submitted licenses, certifications, and accreditations in the enrollment package that is forwarded to the state and/or RO.

Once the contractor receives the approval letter or tie-in notice from the RO, the contractor is encouraged, but not required, to contact the RO, state agency, or provider for the applicable licensing and/certification data and to enter it into PECOS.

C. Form CMS-20134

To operate as an MDPP supplier, no licensure or certificate is needed. Rather, to be eligible to enroll as an MDPP supplier, the organization must have preliminary or full recognition from the Center for Disease Prevention and Control's (CDC) Diabetes Prevention Recognition Program (DPRP). For processing details, please refer to section 15.5.2.6.

15.5.2.2 – Correspondence Address and E-mail Addresses (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Correspondence Address

The contractor may accept a particular correspondence address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the correspondence address. It cannot be the address of a billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

B. Correspondence Telephone Number

The provider may list any telephone number it wishes as the correspondence phone number. The number need not link to the listed correspondence address. If the provider fails to list a correspondence telephone number and it is required for the application submission, the contractor shall develop for this information – preferably via email or fax. The contractor shall accept a particular phone number if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the telephone number.

C. Email Addresses

An email address listed on the application can be a generic email address. It need not be that of a specific individual. The contractor may accept a particular email address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider.

D. Contact Persons

Unless stated otherwise in this chapter or in another CMS directive - or unless the provider requests that the contractor communicate with only a specific individual (e.g., an authorized official) or via specific means (e.g., only via the correspondence email address) - the contractor has the discretion to use the contact persons listed in section 13 of the Form CMS-855 or Form CMS-20134 for all written and oral communications (e.g., mail, email, telephone) related to the provider's Medicare enrollment. Such communication need not be restricted to a particular enrollment application of the provider's that the contractor is currently processing. Nor is the contractor required (again, unless either CMS or the provider directs otherwise) to send certain materials to the correspondence mailing or email address rather than the contact person's mailing or email address.

15.5.2.3 – Accreditation

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

If the provider checks "Yes," the contractor shall ensure that the listed accrediting body is one that CMS recognizes in lieu of a State survey or other certification for the provider type in question. If the accrediting body is not recognized by CMS, the contractor shall advise the provider accordingly. (Note, however, that the provider may not intend to use the listed accreditation in lieu of the State survey and merely furnished the accrediting body in response to the question.)

15.5.2.5 – Section 2 of the Form CMS-855B

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

Any supplier that indicates it is an OT/PT group must complete the questionnaire in section 2J. In doing so:

- If the group indicates that it renders services in patients' homes, the contractor shall verify that the group has an established private practice where it can be contacted directly and where it maintains patients' records.
- If the group answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving the group exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of the group's response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

15.5.2.6 – Section 2 of the Form CMS-855I

(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

A. Specialties

On the CMS-855I, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. Non-physician practitioners must indicate their supplier type.

The contractor shall deny the application if the individual fails to meet the requirements of his/her physician specialty or supplier type.

B. Education for Non-Physician Practitioners

The contractor shall verify all required educational information for non-physician practitioners. While the non-physician practitioner must meet all Federal and State requirements, he/she need not provide documentation of courses or degrees taken to satisfy these requirements unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the practitioner's submission of documentation- such as a State or school Web site - to validate the person's educational qualifications.

A physician need not submit a copy of his/her degree unless specifically requested to do so by the contractor. To the maximum extent possible, the contractor shall use means other than the physician's submission of documentation- such as a State or school Web site - to validate the person's educational status.

C. Resident/Intern Status

If the applicant is a "resident" in an "approved medical residency program" (as these two terms are defined at 42 CFR §413.75(b)), the contractor shall refer to Pub. 100-02, chapter 15, section 30.3 for further instructions. (The contractor may also want to refer to 42 CFR §415.200, which states that services furnished by residents in approved programs are not "physician services.")

The physician should indicate the exact date that its residency program, internship, or fellowship was completed, so that the appropriate effective date can be issued.

An intern cannot enroll in the Medicare program. (For purposes of this requirement, the term “intern” means an individual who is not licensed by the State because he/she is still in post-graduate year (PGY) 1.) Also, an individual in a residency or fellowship program cannot be reimbursed for services performed as part of that program.

D. Physician Assistants

As stated in the instructions on page 3 of the CMS-855I, physician assistants (PAs) who are enrolling in Medicare need only complete sections 1, 2, 3, 13, 15, and 17 of the CMS- 855I. The physician assistant must furnish his/her NPI in section 1 of the application, and must list his/her employers in section 2E.

The contractor must verify that the employers listed are: (1) enrolled in Medicare, and (2) not excluded or debarred from the Medicare program. (An employer can only receive payment for a PA’s services if both are enrolled in Medicare.) All employers must also have an established record in PECOS. If an employer is excluded or debarred, the contractor shall deny the application.

Since PAs cannot reassign their benefits – even though they are reimbursed through their employer – they should not complete a CMS-855R.

E. Psychologists Billing Independently

The contractor shall ensure that all persons who check “Psychologist Billing Independently” in section 2D2 of the CMS-855I answer all questions in section 2I. If the supplier answers “no” to question 1, 2, 3, 4a, or 4b, the contractor shall deny the application.

F. Occupational/Physical Therapist in Private Practice (OT/PT)

All OT/PTs in private practice must respond to the questions in section 2J of the CMS-855I. If the OT/PT plans to provide his/her services as: (1) a member of an established OT/PT group, (2) an employee of a physician-directed group, or (3) an employee of a non-professional corporation, and that person wishes to reassign his/her benefits to that group, this section does not apply. Such information will be captured on the group’s CMS-855B application.

If the OT/PT checks that he/she renders all of his/her services in patients' homes, the contractor shall verify that he/she has an established private practice where he/she can be contacted directly and where he/she maintains patient records. (This can be the person’s home address, though all Medicare rules and instructions regarding the maintenance of patient records apply.) In addition, section 4D of the CMS-855I should indicate where services are rendered (e.g., county, State, city of the patients' homes). Post office boxes are not acceptable.

If the individual answers “yes” to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for PT/OT services only if it has reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

15.5.2.7 – Section 2 of the CMS-20134

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Type of Supplier

The CMS-20134 application is specifically for organizations furnishing MDPP services to Medicare beneficiaries. In-Person MDPP suppliers participating in the Center for Medicare and Medicaid Innovation’s expanded model, which exclusively furnishes MDPP to beneficiaries in in-person settings with limited exceptions for virtual makeup sessions, may begin enrolling into Medicare on January 1, 2018.

B. CDC DPRP Recognition

To be eligible to enroll as an MDPP supplier, entities must have either:

- MDPP Preliminary recognition or
- CDC DPRP Full Recognition

Note that MDPP preliminary recognition includes both Interim Preliminary Recognition as designated by CMS as well as preliminary DPRP recognition as designated by the CDC.

Certificates or letters of the above recognitions are the only eligibility documents required by Medicare to function as the supplier type in question. Any other licenses, certificates, and permits that are not of a medical nature or are of a medical nature, but not related to MDPP are not required.

To verify recognition status information, the contractor shall also adhere to the following:

- Verify that certificate or letter submitted with the organization’s application indicates that the organization has met preliminary or full recognition with an effective date within a year of the application
- Verify that the organization code indicated in this section (section 2) of the CMS-20134 matches both the organization code on the provided CDC registry and on the certificate.
- Verify that the provided CDC registry indicates that the entity associated with that organizational code has met the recognition level (preliminary or full) indicated on the CMS-20134
- Verify that name associated with the organizational code on CDC’s registry is consistent with the name that is listed on the certificate or letter confirming recognition status.

C. Correspondence Address and Email Address

Refer to processing steps outlined in 15.5.2.2.

15.5.3 – Final Adverse Actions

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Unless stated otherwise, the instructions in this section 15.5.3 apply to the final adverse action sections of the Form CMS-855 and Form CMS-20134:

A. Disclosure of Final Adverse Action

If a final adverse action is disclosed on the Form CMS-855 or Form CMS-20134, the provider must furnish documentation concerning the type of final adverse action being reported, the date of the final adverse action occurred, and what court or governing/administrative body imposed the action. The documentation must be furnished regardless of whether the final adverse action occurred in a state different from that in which the provider seeks enrollment or is enrolled.

In addition:

1. Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the OIG or, in the case of debarment, through the federal agency that took the action. The contractor shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).
2. Scope of Disclosure – All final adverse actions that occurred under the LBN and TIN of the disclosing entity (e.g., applicant; section 5 owner) must be reported.

Example (a) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2009. Each location was under Smith's LBN and TIN. In 2010, two locations were excluded by the OIG and then subsequently revoked by CMS, Smith submits a Form CMS-855S application for a new location on Jones Street. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2010.

Example (b) - An HHA, hospice, and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in section 2 of each applicant's Form CMS- 855A. All three successfully enroll. Six months later, Company X's billing privileges for the HHA are revoked due to an OIG exclusion. Both the hospice and the hospital must report that X was excluded on a Form CMS-855A change request because X is under the provider's LBN and TIN. Assume now that X seeks to enroll an ASC under X's LBN and TIN. The exclusion would have to be reported in section 3 of the ASC's initial Form CMS-855B.

Example (c) – Company Y is listed as the provider/supplier for two HHAs and two suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These four providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y's billing privileges for one of the

DMEPOS suppliers are revoked due to a felony conviction. Y now seeks to enroll an ASC in a fifth State. Y must disclose its felony conviction even though the felony conviction occurred in a state different from that in which the ASC is located.

3. Timeframe – With the exception of felony and misdemeanor convictions all other final adverse actions must be reported in the final adverse legal action of the Form CMS-855 or Form CMS-20134, all final adverse actions must be reported regardless of when the final adverse legal action occurred.
4. Evidence to Indicate Final Adverse Action – There may be instances where the provider or supplier states on Form-855 or Form CMS-20134 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall follow the decision tree in section 15.5.3.1.

Note that MDPP suppliers enrolling through the CMS-20134 are not required to submit any final adverse action as it relates to MDPP coaches submitted on Section 7 of that form.

B. Reportable Final Adverse Actions

Providers and suppliers shall disclose all reportable Final Adverse Actions on their enrollment applications. To satisfy the reporting requirement the provider or supplier shall complete the Final Adverse Legal Action section(s) (Form CMS-855 or Form CMS-20134) in its entirety and attach all applicable documentation concerning the adverse action, to the application. It shall be noted that all final adverse actions must be reported, regardless of whether any records have been expunged or pending appeal.

Reportable Final Adverse Actions that must be disclosed on the Form CMS-855 or Form CMS-20134 include:

1. Felony conviction(s) within 10 years
 - Providers are required to report a felony (Federal or State) when--
 - A conviction has occurred; and
 - The felony judgment (disposition) date is within 10 years, from the submission date of a Form CMS-855 or Form CMS-20134 application.
 - A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.
 - A felony conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.
2. Misdemeanor Conviction Within 10 years
 - Report a misdemeanor conviction (Federal or State) when—

- A conviction has occurred; and
 - The misdemeanor judgment (disposition) date is within 10 years, from the submission date of an Form CMS-855 or Form CMS-20134 application, and
 - The misdemeanor is related to:
 - The delivery of an item/service under Medicare or a State health care item/service
 - The abuse or neglect of a patient in connection with the delivery of a health care item or service
 - Theft, Fraud, Embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health care item/service
 - The interference with or obstruction of any investigation into any criminal offense
 - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance
 - A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.
 - A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.
3. Current or Past Suspension(s)/Revocations(s) of a medical license
 - A medical license board suspends or revokes a medical license for any period of time.
 4. Current or Past Suspensions(s)/Revocation(s) of an accreditation
 - An accrediting body suspends or revokes an accreditation for any period of time.
 5. Current or Past Suspension(s) or Exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)
 - Items/services furnished, ordered or prescribed by a specified individual/entity are not reimbursed under Medicare, Medicaid and/or all other Federal health care programs until the individual or entity is reinstated by the HHS OIG.

6. Current or Past Debarment(s) from participation in any Federal Executive Branch procurement or non-procurement program
 - An individual or entity is suspended throughout the Executive Branch or the Federal government, as it applies to procurement and non-procurement programs. An individual or entity will not be solicited from, contracts will not be awarded to or existing contracts will not be renewed or otherwise extended to those individuals or entities with a debarment. (e.g. GSA debarment)
7. Medicaid exclusion(s), revocation(s) or termination(s) of any billing number
 - A state terminates an active provider agreement or prohibits a provider from enrolling in the Medicaid program.
8. Any other Current or Past Federal Sanction(s)
 - A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP), Corporate Integrity Agreement (CIA)).

C. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855 or CMS-20134, the contractor shall deny the application in accordance with the instructions found in chapter 15.5.3.1.

D. Review of PECOS

If the contractor denies an application or revokes a provider based on a final adverse action, the contractor shall search PECOS to determine whether the person/entity with the final adverse action has any other associations, as it applies (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers).

If such an association is found and there are grounds for revoking the billing privileges of the other provider(s), the contractor shall initiate revocation action against the associate provider(s).

E. Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in section 7, 8, or 12 of the Form CMS-855A has had a final adverse action imposed against it, the contractor shall contact its PEOG BFL for guidance. For any final adverse actions against individuals listed in section 7 of the Form CMS-20134, contractors shall refer to 15.5.9 where this process is outlined in detail.

F. System for Award Management (SAM)

When an entity or individual is listed as debarred in the SAM (formerly, the General Services Administration Excluded Parties List System), the SAM record may identify associated entities and persons that are also debarred. To illustrate, suppose John Smith is identified as

debarred. The SAM record may also list individuals and entities associated with John Smith that are debarred as well, such as “John Smith Company,” “Smith Consulting,” “Jane Smith,” and “Joe Smith.”

If the contractor learns via the Form CMS-855 or CMS-20134 verification process, a Unified Program Integrity Contractor (UPIC) referral, or other similar means that a particular person or entity is debarred, the contractor shall search the person/entity in the SAM to see if the SAM record discloses any associated parties that are debarred. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms that Jane Smith is debarred and PECOS shows Jane Smith as an owner of Entity X, the contractor shall, as applicable, initiate revocation proceedings against X.

15.5.3.1 – Reviewing for Adverse Legal Actions

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

The contractor shall address the reporting of Adverse Legal Actions (ALA) in its review of initial enrollment, revalidation, reactivation or change of information applications submitted by a provider or supplier. The contractor may receive information of ALA not yet reported by the provider or supplier from CMS, other contractors or through the application screening process. The contractor shall consider this information and take action as described in (but not limited to) sections 15.5.3 and 15.27 of this chapter.

Providers and suppliers shall include all reportable ALAs on their enrollment applications. This information must be reported either at the time of the initial/revalidation application by the provider/supplier, or must be reported by the provider/supplier within the reporting requirements as specified in 42 CFR § 424.516 and section 15.10.1 of this chapter. Reportable ALAs include criminal convictions within the last 10 years, Federal Health Care programs exclusions/debarments, and revocation/suspension of a license to provide health care by any State licensing authority. Non-reportable ALAs include, but are not limited to, probations and malpractice suits. The contractors shall refer to 42 CFR 424.535 § (a)(2), 42 CFR 424.535 § (a)(3), 42 CFR §1001.2 and the CMS-855 forms for further clarification of what ALAs are to be reported. All applicable ALAs shall be reported, regardless of whether any records were expunged, pending appeals, or waivers being granted.

In order to assist a contractor in determining what actions to take when an ALA is involved, CMS has produced an ALA Decision Tree (see below) for the contractor to use as a guide. The contractor shall follow the ALA Decision Tree when they receive ALA information regarding a provider or supplier, and validate this information against the provider/supplier enrollment application. The contractor shall follow the ALA Decision Tree and shall not develop to the provider or supplier for reported or unreported ALA(s).

I. INITIAL/ REACTIVATION APPLICATIONS

Any actionable ALA reported by a provider shall result in the denial of an application. A MAC shall not develop the ALA. A MAC shall then continue evaluating all ALAs reported and not reported.

1.1 LICENSURE – INITIAL/REACTIVATION APPLICATIONS

| Provider holds a valid accreditation/medical license in the state in which they are enrolling | Did the provider report the ALA taken on their license/ accreditation? | MAC Action | Notes |
|---|--|--|---|
| <p>Provider's accreditation/medical license was previously suspended / revoked / voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority.</p> | <p>Yes</p> | <p>Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.2 – 1.8.</p> | <p>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/revocation. e.g. Felonies.</p> |
| <p>Provider's accreditation/medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority.</p> | <p>No</p> | <p>Deny application under 42 CFR § 424.530 (a)(4) unless the license adverse action occurred more than ten years prior to the date of application receipt. If a license suspension/revocation /surrender in lieu of disciplinary proceedings occurred more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision.</p> | <p>42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action.</p> <p>MACs shall consider whether other denial reasons exist. Refer to section (s) 1.2 – 1.8.</p> <p>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/ revocation. e.g. Felonies</p> <p>No Reporting Requirement:</p> <ul style="list-style-type: none"> • A suspension is “stayed” in its entirety. • Advertising/Administrative penalties • Fines, Violations, Stipulations, Reprimands |

1.2 FELONIES – INITIAL/REACTIVATION APPLICATIONS

| Felony | Did the provider report their felony? | MAC Action | Notes |
|---|---------------------------------------|---|---|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a felony and/or a crime that is punishable by imprisonment for a period of one year or more | Yes or No | Send application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | All felony convictions shall be forwarded to CMS for review and decision. |

1.2 MISDEMEANORS – INITIAL/REACTIVATION APPLICATIONS

| Misdemeanor | Did the provider report their misdemeanor? | MAC Action | Notes |
|---|--|--|-------|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare, abuse or patient, financial misconduct, interference with a criminal investigation, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 & 1.3 – 1.8. | |
| Provider or someone with ownership interest and/or managing control has been of a misdemeanor that is related to healthcare, abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance. | No | Send ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | |

1.3 EXCLUSION (ACTIVE) – INITIAL/REACTIVATION APPLICATIONS

| Current Exclusion | Did the provider report their current exclusion? | MAC Action | Notes |
|--|--|---|--|
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | Yes | Deny application under 42 CFR § 424.530 (a)(2) | <p>MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.2 & 1.4 - 1.8.</p> <p>A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to EnrollmentReview@cms.hhs.gov for review.</p> |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | No | Deny application under 42 CFR § 424.530 (a)(2) & (a)(4) | 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action. However § 424.530 (a)(2), in this particular scenario, would still be apply. |

1.4 EXCLUSION (EXPIRED) – INITIAL/REACTIVATION APPLICATIONS

| Exclusion period has expired | Did the provider report their past exclusion? | MAC Action | Notes |
|---|---|--|---|
| <p>Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion has been reinstated by HHS and/or OIG.</p> | <p>Yes</p> | <p>Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.3 & 1.5 – 1.8.</p> | |
| <p>Provider or someone with ownership interest and/or managing control has a and/or OIG exclusion that has expired and has been reinstated by HHS and/or OIG.</p> | <p>No</p> | <p>Deny application under 42 CFR § 424.530 (a)(4) unless the provider was reinstated more than ten years prior to the date application receipt. If a provider has been reinstated more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision.</p> | <p>MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.3 & 1.5 – 1.8.</p> <p>42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse</p> |

1.5 MEDICARE PAYMENT SUSPENSION (CURRENT) – INITIAL/REACTIVATION APPLICATIONS

| Medicare Payment Suspension is currently active | Did the provider report their current Medicare Payment Suspension? | MAC Action | Notes |
|---|--|---|--|
| Current Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.4 & 1.6-1.8 | Providers are NOT required to report Current or Past Medicare Payment Suspensions to CMS. MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.4 & 1.6 – 1.7, 1.8. |

1.6 MEDICARE PAYMENT SUSPENSION (PAST) – INITIAL/REACTIVATION APPLICATIONS

| Medicare Payment Suspension that is NOT currently active | Did the provider report their past Medicare Payment Suspension? | MAC Action | Notes |
|--|---|--|--|
| Past Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.5 & 1.8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions to CMS. MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.5 & 1.7, 1.8. |

1.7 MEDICARE REVOCATION – INITIAL/REACTIVATION APPLICATIONS

| Medicare Revocation | Did the provider report their Medicare Revocation? | MAC Action | Notes |
|--|--|---|--|
| All prior enrollment bar(s) have expired | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.6, 1.8. | Providers are NOT required to report Current or Past Medicare Revocations to CMS. MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.6, 1.8. |
| Enrollment bar is active in the state that the provider is enrolling | Yes or No | Return the application | |
| Enrollment bar is active in a state other than the enrolling state | Yes or no | Return the application. | |

1.8 FEDERAL SANCTION (CIVIL MONETARY PENALTY OR CORPORATE INTEGRITY AGREEMENT) – INITIAL/REACTIVATION APPLICATIONS

| Federal Sanction | Did the provider report their Federal Sanction? | MAC Action | Notes |
|---|---|---|--|
| The provider has a current or past federal sanction | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.7. | |
| The provider has a current or past federal sanction | No | MACs are only required to verify via SAM/OIG checks whether a provider has a CMP/CIA. If encountered here or otherwise, MAC shall send the application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.7. |

II. REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS

Any actionable ALA reported by a provider shall result in a revocation. A MAC shall not develop the ALA. If a MAC discovers an ALA that has not been reported by a provider, a MAC shall record the ALA in Section 3 of PECOS and note that they were the entity that discovered the ALA. A MAC shall then continue evaluating all ALAs reported and not reported.

2.1 LICENSURE – REVALIDATIONS/ CHANGE OF INFORMATION APPLICATIONS

| Provider holds a valid accreditation/medical license in the state in which they are revalidating or changing information | Did the provider report the ALA taken on their license/ accreditation? | MAC Action | Notes |
|--|--|--|--|
| <p>Provider’s accreditation/ medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority.</p> | <p>Yes</p> | <p>MACs shall check whether the provider billed for dates of service during the period of license suspension/revocation/surrender during disciplinary proceedings. If the provider billed for dates of service during this period, the MACs shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov.</p> <p>If the provider did not bill during the period of license suspension, the application shall be processed unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.2 – 2.8.</p> | <p>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/revocation/ surrender. e.g. Felonies.</p> |
| <p>Provider’s accreditation/ medical license was previously suspended/revoked in any state/voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing</p> | <p>No</p> | <p>MACs shall check whether the provider billed for dates of service during the period of license suspension/revocation. If the provider billed for dates of service during this period, the MACS shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov.</p> <p>If the provider did not bill for dates of service during this period, the provider shall be revoked under 42 CFR § 424.535 (a)(4).</p> <p>If a license suspension/revocation /surrender in lieu of disciplinary proceeding occurred more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision.</p> <p>MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.2 – 2.8.</p> | <p>42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action.</p> <p>MACs shall read board orders thoroughly to determine if:</p> <ul style="list-style-type: none"> - there are other adverse actions associated with the license suspension/revocation/ surrender. e.g. Felonies <p>No Reporting Requirement:</p> <p>A suspension is “stayed” in its entirety.</p> <p>Advertising/Administrative penalties</p> <p>Fines, Violations, Stipulations, Reprimands</p> |

2.2 FELONIES — REVALIDATION/ CHANGE OF INFORMATION APPLICATIONS

| Felony | Did the provider report their felony? | MAC Action | Notes |
|---|---------------------------------------|---|---|
| Provider or someone with ownership interest and/or managing control been adjudged guilty of a felony and/or a crime that is punishable by imprisonment. | Yes or No | Send application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | All felonies shall be forwarded to CMS for review and decision. |

2.2 MISDEMEANORS – REVALIDATION/ CHANGE OF INFORMATION APPLICATION

| Misdemeanor | Did the provider report their misdemeanor? | MAC Action | Notes |
|--|--|--|-------|
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare, abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or un- lawful manufacture, distribution, prescription or dispensing of a controlled substance. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 & 2.3 – 2.8. | |
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare, abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or un- lawful manufacture, distribution, prescription or dispensing of a controlled substance. | No | Send ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | |

2.3 EXCLUSION (ACTIVE) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Current Exclusion | Did the provider report their current exclusion? | MAC Action | Notes |
|---|--|--|---|
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion. | Yes | Revoke provider under 42 CFR § 424.535 (a)(2) | <p>MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.2 & 2.4 - 2.8.</p> <p>All waivers shall be sent to EnrollmentReview@cms.hhs.gov for review.</p> |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG Exclusion. | No | Revoke provider under 42 CFR § 424.535 (a)(2) and (a)(4) | <p>MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.2 & 2.4 - 2.8.</p> <p>All waivers shall be sent to EnrollmentReview@cms.hhs.gov for review.</p> <p>42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action. However § 424.535 (a)(2), in this particular scenario, would still be apply.</p> |

2.4 EXCLUSION (EXPIRED) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Exclusion period has expired | Did the provider report their past exclusion? | MAC Action | Notes |
|--|---|--|--|
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion that has expired and has been reinstated by HHS and/or OIG. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.3 & 2.5 – 2.8. | |
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion that has expired and has been reinstated by HHS and/or OIG. | No | Revoke provider under 42 CFR § 424.535 (a) (4) unless the provider was reinstated more than ten years prior to the date of application receipt. If a provider has been reinstated more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision. | 42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action. |

2.5 MEDICARE PAYMENT SUSPENSION (CURRENT) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Medicare Payment Suspension that is currently active | Did the provider report their current Medicare Payment Suspension? | MAC Action | Notes |
|---|---|---|--|
| Current Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.5 & 2.7. 2.8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions. |

2.6 MEDICARE PAYMENT SUSPENSION (PAST) – REVALIDATION/CHANGE OF INFORMATION

| Medicare Payment Suspension that is NOT currently active | Did the provider report their past Medicare Payment | MAC Action | Notes |
|---|--|---|--|
| Past Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.5 & 2.7, 2.8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions. |

2.7 MEDICARE REVOCATION – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Any Medicare Revocation | Did the provider report | MAC Action | Notes |
|--|--------------------------------|---|---|
| All prior enrollment bar (s) have expired | Yes or No | Process unless there is reported adverse action that processing of the application. Refer to section(s) 2.1 – 2.6, 2.8. | Providers are NOT required to Past Medicare Revocations to CMS. MACs shall consider whether other revocation reasons exist. Refer to 2.1 – 2.6, 2.8. |
| Enrollment bar is active in a state other than the current state | Yes or No | Process the application unless there is another reported adverse legal action that precludes the processing of the | Providers are NOT required to Past Medicare Revocations to CMS. MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.6, 2.8. |

2.8 FEDERAL SANCTION (CIVIL MONETARY PENALTY OR CORPORATE INTEGRITY AGREEMENT) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

| Federal Sanction | Did the provider report their | MAC Action | Notes |
|---|--------------------------------------|---|--|
| The provider has a current or past federal sanction | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.7. | |
| The provider has a current or past federal sanction | No | MACs are only required to verify via SAM/OIG checks whether a provider has a CMP/CIA. If encountered here or otherwise, MAC shall send the application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | MACs shall consider whether other denial reasons exist. Refer to section(s) 2.1 – 2.7. |

15.5.4 – Practice and Administrative Location Information (Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, and the CMS-20134.

The instructions in section 15.5.4.1 apply only to the Form CMS-855A; the instructions in section 15.5.4.2 apply only to the Form CMS-855B; and the instructions in section 15.5.4.3 only apply to the Form CMS-855I; and the instructions in section 15.5.4.4 only apply to the Form CMS-20134.

A. Practice and Administrative Location Verification

The contractor shall verify that the practice and administrative locations listed on the application actually exist. If a particular location cannot at first be verified, the contractor shall request clarifying information; for instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 15.7.3 of this chapter (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints). The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction. For MDPP suppliers enrolling through the Form CMS-20134, the entity must maintain a primary business telephone number listed under the name of the organization in public view. Public view could signify, for example, that the phone number is listed on a website, on flyers and materials. Additional information on this requirement and the need for a site visit is detailed in 15.6.1.1.3.

Additionally, once the verification of practice or administrative locations is complete, the contractor need not verify the address via the Internet (for example, 411.com, USPS.com, etc.). Address functionality used in PECOS verifies the validity of an address with the United States Postal Service (USPS). Additional

verification is only needed if address functionality in PECOS cannot validate an actual address.

Also:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the Form CMS-855I, Form CMS-855B, or CMS-20134 specific to its supplier type (e.g., psychologists, physical therapists, MDPP supplier), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

- For providers/suppliers paid via the Fiscal Intermediary Shared System (FISS), the practice location name entered into the Provider Enrollment, Chain and Ownership System (PECOS) shall be the “doing business as” name (if it is different from the legal business name). For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider’s “special payment” address (section 4 of the Form CMS-855 or CMS-20134) or EFT information has changed. The provider should submit a Form CMS-855, Form CMS-20134, or Form CMS-588 request to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855, or Form CMS-20134 as well as Form CMS-588. The Durable Medical Equipment Medicare Administrative Contractors are responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the “special payment” address section of the Form CMS-855 or Form CMS-20134 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall

verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855 or Form CMS-20134 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.
- An updated section 4 that identifies the provider’s desired “special payments” address.

The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.

The “special payment” address may only be one of the following:

- One of the provider’s practice locations
- A P.O. Box
- A Lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement, at least with respect to any special payments that might be made, may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- The provider’s billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.
- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a Part A chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.
- Correspondence address

15.5.4.1 – Section 4 of the Form CMS-855A
(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)

A. General Information

A hospital or other provider must list all addresses where it - and not a separately enrolled provider or supplier it owns or operates, such as a nursing home - furnishes services. The provider's primary practice location should be the first location identified in section 4A and the contractor shall treat it as such – unless there is evidence indicating otherwise - for purposes of entry into the Provider Enrollment, Chain and Ownership System (PECOS). **NOTE:** Hospital departments located at the same address as the main facility need not be listed as practice locations on the Form CMS-855A.

If a practice location (e.g., hospital unit) has a CMS Certification Number (CCN) that is in any way different from that of the main provider, the contractor shall create a separate enrollment record in PECOS for that location; this does not apply, however, to home health agency (HHA) branches, outpatient physical therapy/outpatient speech pathology (OPT/OSP) extension sites and transplant centers.

An HHA should complete section 4A with its administrative address.

If the provider's address and/or telephone number cannot be verified, the contractor shall request clarifying information from the provider. If the provider states that the facility and its phone number are not yet operational, the contractor may continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified. For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

B. Verification of HHA Sites

If the contractor receives an application from an HHA that has the same general practice location address as another enrolled (or enrolling) HHA and the contractor has reason to suspect that the HHAs may be concurrently operating out of the same suite or office, the contractor shall notify the National Site Visit Contractor of this at the time the contractor orders the required site visit through PECOS.

C. Out-of-State Practice Locations

If a provider is adding a practice location in another State that is within the contractor's jurisdiction, a separate, initial Form CMS-855A enrollment application is not required if the following 5 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),
- The location does not have a separate tax identification number (TIN) and

legal business name (LBN),

- The State in which the new location is being added does not require the location to be surveyed,
- The applicable RO does not require the new location or its owner to sign a separate provider agreement, and
- The location is not a federally qualified health center (FQHCs are required to separately enroll each site)

Consider the following examples:

1. The contractor's jurisdiction consists of States X, Y and Z. Jones Skilled Nursing Facility (JSNF), Inc., is enrolled in State X with 3 sites. It wants to add a fourth site in State Y. The new site will be under JSNF, Inc. JSNF will not be establishing a separate corporation, LBN or TIN for the site, and - per the State and RO - a separate survey and provider agreement are not necessary. Since all 5 conditions above are met, JSNF can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.
2. The contractor's jurisdiction consists of States X, Y and Z. JSNF, Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate legal entity - JSNF, LP. The fourth location must be enrolled via a separate, initial Form CMS-855A.
3. The contractor's jurisdiction consists of States X, Y and Z. Jones Hospice (JH), Inc., is enrolled in State X with 1 location. It wants to add a second location in State Z under JH, Inc. However, it has been determined that a separate survey and certification of the new location are required. A separate, initial Form CMS-855A for the new location is required.

15.5.4.2 – Section 4 of the Form CMS-855B

(Rev. 499, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

A. Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers

If the applicant's address or telephone number cannot be verified, the contractor shall contact the applicant for further information. If the supplier states that the facility or its phone number is not yet operational, the contractor shall continue processing the application. However, it shall indicate in its recommendation letter that the address and telephone number of the facility could not be verified.

For purposes of PECOS entry, the contractor can temporarily use the date the certification statement was signed as the effective date.

B. Reassignment of Benefits

Per Pub. 100-04, chapter 1, section 30.2.7, a contractor may permit a reassignment of benefits to any eligible entity regardless of where the service was rendered or whether the entity owned or leased that location. As such, the contractor need not verify the entity's ownership or leasing arrangement with respect to the reassignment.

C. Ambulance Companies

If an ambulance company will be furnishing all of its services in the same contractor jurisdiction, the supplier should list:

- Each site at which its vehicles are garaged in section 4A. (The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)
- Each site from which its personnel are dispatched in section 4A. (The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)
- Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E. (The supplier can only have one base of operations.)

If the supplier will be furnishing services in more than one contractor jurisdiction, it shall follow the applicable instructions in section 15.5.18 of this chapter.

D. Out-of-State Practice Locations

If a supplier is adding a practice location in another State that is within the contractor's jurisdiction, a separate, initial Form CMS-855B enrollment application is not required if the following 5 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),
- The location does not have a separate tax identification number (TIN) and legal business name (LBN),
- The State in which the new location is being added does not require the location to be surveyed,
- The applicable RO does not require the new location or its owner to sign a

separate supplier agreement, and

- The location is not an independent diagnostic testing facility (IDTFs are required to separately enroll each site)

Consider the following examples:

1. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no State or RO involvement with group practices, all 5 conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.
2. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.
3. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.
4. The contractor's jurisdiction consists of States X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Z under JASC, Inc. However, it has been determined that a separate survey and certification of the new site are required. A separate, initial Form CMS-855B is therefore necessary.

15.5.4.3 – Section 4 of the Form CMS-855I

(Rev.717, Issued: 05-12-17, Effective: 05-15-17, Implementation: 05-15-17)

A. Solely-Owned Organizations

The former practice of having solely-owned practitioner organizations (as explained and defined in section 4A of the CMS-855I) complete a CMS-855B, a CMS-855R, and a CMS-855I has been discontinued. All pertinent data for these organizations can be furnished via the CMS-855I alone. The contractor, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. (**NOTE:** A solely-owned supplier type that normally completes the

CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though section 4A makes mention of solely-owned LLCs. Use of section 4A of CMS-855I is limited to suppliers that perform physician or practitioner services.)

Sole proprietorships need not complete section 4A of the CMS-855I. By definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.

In section 4A, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the State in which the supplier is located.

The contractor shall verify all data furnished in section 4A (e.g., legal business name, TIN, adverse legal actions). If section 4A is left blank, the contractor may assume that it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes section 4A to enroll in Medicare can generally submit change of information requests to Medicare via the CMS-855I. However, if the change involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R).

B. Individual Affiliations

If the applicant indicates that he/she intends to render all or part of his/her services in a group setting, the contractor shall ensure that the applicant (or the group) has submitted a CMS-855R for each group to which the individual plans to reassign benefits. The contractor shall also verify that the group is enrolled in Medicare. If it is not, the contractor shall enroll the group prior to approving the reassignment.

C. Practice Location Information

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in section 4C. In addition, if a practitioner renders services in a retirement or assisted living community, section 4C must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

If the physician or non-physician practitioner uses his/her home address as their practice location and exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

D. Sole Proprietor Use of EIN

The practitioner must obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

E. NPI Information for Groups

If a supplier group/organization is already established in PECOS (i.e., status of "approved), the physician or non-physician practitioner is not required to submit the NPI in 4B2 of the 855I. In short, if group/organization is already established in PECOS, the group/organization does not need to include an NPI in section 4B2. The only NPI that the physician or non-physician practitioner must supply is the NPI found in section 4C.

NOTE: Physicians and non-physician practitioners are required to supply the NPI in section 4B2 of the CMS-855I for groups/organizations not established in PECOS with a status of "approved."

F. Out-of-State Practice Locations

If a supplier is adding a practice location in another State, a separate, initial Form CMS-855I enrollment application is required for that location even if:

- The location is part of the same organization (e.g., a solely-owned corporation),
- The location has the same tax identification number (TIN) and legal business name (LBN), and
- The location is in the same contractor jurisdiction.

To illustrate, suppose the contractor's jurisdiction consists of States X, Y and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. He wants to add a third location in State Y under his social security number and his sole proprietorship's employer identification number. A separate, initial Form CMS-855I application is required for the State Y location.

15.5.4.4 – Section 4 of the Form CMS-20134

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The MDPP set of services is unique in that it is delivered in group settings and can be delivered by non-traditional health care providers who meet certain eligibility criteria. Given this aspect of MDPP suppliers, MDPP services are often delivered within community locations to increase access. Thus, the locations associated with MDPP suppliers differ slightly than traditional practice locations of other health care provider and suppliers.

MDPP suppliers must have at least one administrative location, and must report all administrative locations on their Form CMS-20134 or PECOS equivalent. As noted in section 15.1.1, an administrative location is the physical location associated with the supplier's operations, from where coaches are dispatched or based, and where MDPP services may or may not be furnished. If an entity enrolls as an MDPP supplier, but does not furnish MDPP services at their administrative location, it should deliver and disclose any and all community settings where they furnish MDPP services. With respect to MDPP, a community setting is a location where the supplier furnishes MDPP services outside of their administrative locations in a meeting location open to the public, but not primarily associated with the supplier.

A. Administrative Locations

All administrative locations associated with the supplier must be disclosed on the enrollment application. Administrative locations must:

- not be a private residence
- must have signage posted on the exterior of the building or suite, in a building directory, or on materials located inside of the building. Such signage may include, for example, the MDPP supplier's legal business name or DBA, as well as hours of operation.
- must be open for business and have employees, staff, or volunteers present during operational hours

All administrative locations related to the MDPP supplier must be disclosed, however, given that MDPP suppliers may be non-traditional health care providers engaged in non-health care related activities, not all organizations run by the entity may constitute an administrative location. For example, if an advocacy organization operated 2 sites, however only one of these sites offered MDPP services, only the site offering MDPP would be considered an administrative location. Should a coach be based or dispatched from their non-administrative location site to offer MDPP services in community settings, that location would become an administrative location. Detail on the frequency with which MDPP suppliers must report this change is outlined in 15.4.6.4.C.

Given that MDPP suppliers are designated as high categorical risk, their administrative locations are subject to site visits. Additional information for the site visit is outlined in 15.6.1.1.3.

B. Community Settings

When determining whether a location is considered an administrative location or a community setting, MDPP suppliers must consider whether their organizational entity is the primary user of that space and whether coaches are based or dispatched from this location. If so, the location would be considered an administrative location, even if this location dually provides other services benefiting the community. In comparison, community settings are locations not primarily

associated with the supplier where many activities occur, including MDPP services.

MDPP suppliers are required to update their enrollment application with locations where services are furnished in community settings. These settings are not subject to site visits, but serve a form of recordkeeping and accountability for the MDPP supplier.

C. Out-of State Administrative Locations

If a supplier is adding an administrative location in another State that is within the contractor's jurisdiction, a separate, initial Form CMS-20134 enrollment application is not required if the following 3 conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership),
- The location does not have a separate tax identification number (TIN) and legal business name (LBN),
- The location has the same CDC organizational code

Consider the following examples:

1. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 administrative locations. It wants to add a fourth administrative location in State Y. The new administrative location will be under JGP, Inc., and will use the same organizational code for their recognition. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no State or RO involvement with MDPP suppliers, all 3 conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., organizational code, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location. Given that the jurisdiction-organizational code combination remains the same, the contractor need not create a new PTAN for the State Y administrative location.

2. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new administrative location will be under JGP, Inc., and will use the same organizational code for their recognition. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location, however, it will have a different CDC organizational code than their other administrative locations. Because they are adding a location with a new organizational code, LGP can add the fourth location via an initial application. Given that this is a new organizational code-jurisdiction combination, the contractor shall create a separate

PECOS enrollment record for the State Y location with a new PTAN.

3. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 administrative locations. It wants to add a fourth location in State Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-20134.

4. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.

5. The contractor's jurisdiction consists of States X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in State X with 3 administrative locations. It wants to add a fourth administrative location in State Z under JASC, Inc. However, it has been determined that the new site includes a new organizational code. A separate, initial Form CMS-20134 is therefore necessary.

15.5.5 – Owning and Managing Organizations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(This section only applies to section 5 of the Form CMS-855A, Form CMS-855B, and Form CMS-20134. It does not apply to the Form CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the Form CMS-855 or Form CMS-20134:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

The following illustrates the difference between direct and indirect ownership:

EXAMPLE: The supplier listed in section 2 of the Form CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. Company A is considered to be a direct owner of the supplier (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the supplier. In other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.

See the instructions for section 5 of the Form CMS-855 or CMS-20134 on the enrollment application for additional information on indirect ownership.

2. Mortgage or security interest

For purposes of enrollment, ownership also includes "financial control." Financial

control exists when:

(a) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, and

(b) The interest is equal to or exceeds 5 percent of the total property and assets of the provider.

All entities with at least a 5 percent mortgage, deed of trust or other security interest in the provider must be reported in section 5. This frequently will include banks, other financial institutions, and investment firms,

3. Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

4. For limited partnerships, any limited partnership interest that is 10 percent or greater.

5. Managing control of the provider or supplier

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, the entity could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

The organizations referred to above generally fall into one or more of the following categories:

- Corporations
- Partnerships and limited partnerships
- Limited liability companies
- Charitable and religious organizations
- Governmental/tribal organizations
- Banks and financial institutions
- Investment firms
- Holding companies
- Trusts and trustees
- Medical providers/suppliers
- Consulting firms
- Management services companies
- Medical staffing companies
- Non-profit entities

In section 5(A)(2) of the Form CMS-855 or the Form CMS-20134, as appropriate, the provider must indicate the type(s) of organizational categories the reported entity falls into.

The following principles also apply with respect to section 5:

a. Diagrams – In addition to completing section 5(A):

- The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other. (This applies to the Form CMS-855A, CMS-855B, CMS-855S, and CMS-20134.)
- If the provider is a skilled nursing facility (SNF), it must submit a diagram/flowchart identifying the organizational structures of all of its owners, including those that were not required to be listed in section 5 or 6. This must be submitted in addition to the diagram/flowchart in the previous bullet.

These diagrams/flowcharts must be submitted for initial enrollments, revalidations, Form CMS-855 reactivations, Form CMS-20134 reactivations, and upon any contractor request.

b. Percentage of Interest (section 5(B)) – The provider need not:

- Disclose a percentage of managerial control
- Submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.

c. Section 2 - Any entity listed as the provider in section 2 of the Form CMS-855 or CMS-20134 need not be reported in section 5A. The only exception involves governmental entities, which must be identified in section 5A even if they are already listed in section 2.

d. Governmental and Tribal Organization Letter - For governmental and tribal organizations, the letter referred to in the Form CMS-855 or CMS-20134 instructions for section 5 must be signed by an appointed or elected official of the governmental or tribal entity who has the authority to legally and financially bind the governmental or tribal entity to the laws, regulations, and program instructions of Medicare. This governmental or tribal official is not required to be an authorized official, or vice versa.

e. Non-Profit Organizations - Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing

body must be listed in section 5A of the Form CMS-855 or CMS-20134. The provider must submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the provider may submit any other documentation that supports its claim (e.g., written documentation from the State).

Governmental and tribal entities need not submit a copy of a 501(c)(3) if it is otherwise obvious to the contractor that the entity is a governmental or tribal entity. The contractor can assume that the governmental or tribal entity is non-profit.

- f. IRS CP-575 - Owing/managing organizations need not furnish an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a potential discrepancy between the organization's reported legal business name and tax identification number).
- g. Documentation – Proof of ownership, managerial control, security interest, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.
- h. Partnerships – Only partnership interests in the enrolling provider need be disclosed in section 5. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 5.
- i. Disregarded Entities – In general, a “disregarded entity” is a term the IRS uses for an LLC that – for federal tax purposes only – is effectively indistinguishable from its single owner/member. The LLC's income and expenses are shown on the owner's personal tax return. The LLC itself does not pay taxes.

If an enrolling provider claims that it is a disregarded entity, the contractor need not obtain written confirmation of this from the provider notwithstanding the instruction in section 17 of the Form CMS-855 or the Form CMS-20134 that such confirmation is required. As a disregarded entity does not receive a CP-575 form from the IRS confirming its legal business name (LBN) and tax identification number (TIN), the contractor may accept from the enrolling provider any government form (such as a W-9) that lists its LBN and TIN. The disregarded entity's LBN and TIN shall be listed in section 2B1 of the Form CMS-855 or Form CMS-20134.

15.5.6 – Owning and Managing Individuals

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(This section applies to section 6 of the Form CMS-855A, the Form CMS-855B, the

Form CMS-855I, and the Form CMS-20134.)

All individuals who have any of the following must be listed in section 6A:

1. A 5 percent or greater direct or indirect ownership interest in the provider.
2. A 5 percent or greater mortgage or security interest in the provider.

(See section 15.5.5 of this chapter for more information on direct and indirect ownership, and on mortgage and security interests.)

3. Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.
4. For limited partnerships, any limited partnership interest that is 10 percent or greater.
5. Managing control of the provider. (For purposes of enrollment, such a person is considered to be a “managing employee.” A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.)
6. Officers and directors/board members, if – and only if - the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors. If a non-profit corporation has “trustees” instead of officers or directors, these trustees must be listed in section 6 of the Form CMS-855 or the Form CMS-20134.) Only officers and directors of the enrolling provider must be reported. Board members of the provider’s indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in section 6. However, there may be situations where the officers and directors/board members of the enrolling provider’s corporate owner/parent also serve as the enrolling provider’s officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner’s officers and directors/board members would have to be disclosed as the provider’s officers and directors/board members in section 6.

With respect to corporations, the term “director” refers to members of the board of directors. If a corporation has, for instance, a Director of Finance who nonetheless is not a member of the board of directors, he/she would not need to be listed as a director/board member in section 6. However, he/she may need to be listed as a managing employee in section 6.

In addition:

- The provider need not disclose a percentage of: (1) control as an officer or director, (2) W-2 or contracted managerial control, or (3) operational control. Also, the provider need not submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.
- Government entities need only list their managing employees in section 6 of the Form CMS-855, as they do not have owners, partners, corporate officers, or corporate directors.
- The applicant must list at least one managing employee in section 6 if it is completing the Form CMS-855A, the Form CMS-855B or the Form CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if he/she does not have one.
- All managing employees at any of the practice locations listed in section 4C of the Form CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the chief executive officer of a hospital listed in section 4C), or (2) are managing employees of any group/organization to which the practitioner will be reassigned his/her benefits, need not be reported.
- The contractor need not request a copy of the individual's W-2 to confirm that he/she is a W-2 employee (as opposed to a contracted employee), although it reserves the right to do so.
- Proof of ownership, managerial control, security interests, etc., need not be submitted unless the contractor requests it.
- Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. Of course, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 6.

See section 15.5.6.1 of this chapter for special instructions regarding the reporting of tax identification numbers of owning and managing individuals.

15.5.6.1 – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Consistent with sections 1124 and 1124A of the Social Security Act, the TINs (employer identification numbers or social security numbers) of all entities and individuals listed in sections 5 and 6, respectively, of the Form CMS-855 and Form CMS-20134 must be disclosed. If the contractor receives an initial, reactivation, revalidation, or change of ownership application from a provider and the provider fails to disclose the TIN of a particular organization or individual listed in section 5 or 6, the contractor shall follow normal development procedures for requesting the TIN. In doing so, if the contractor learns or determines that the TIN was not furnished because the entity or person in question is foreign, the contractor shall take the following steps:

- a. The contractor shall ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN). (Only one inquiry is needed.)
 - (1) If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.
 - (2) If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN, and (ii) the provider must furnish the TIN/ITIN on the Form CMS-855 with a newly-signed certification statement within 90 days of the contractor's request.
 - (3) If the provider states that the person or entity is unable to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN, and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.
- b. If the provider timely submits the explanation in (a)(3) above, the contractor shall forward the explanation to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). PEOG will notify the contractor as to how the application should be handled.
- c. If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN in (a)(2), the contractor shall – unless another CMS instruction directs otherwise - reject the application in accordance with the procedures identified in this chapter.

In addition:

- If the contractor exceeds timeliness standards on a particular application because of the procedures outlined in this section, the contractor shall document the provider file in accordance with section 15.7.3 of this chapter.

For purposes of this section 15.5.6.1 only, the term “change of ownership” - as used in the first paragraph of this section - refers to (1) CHOW, acquisition/merger, and consolidation applications submitted by the new owner, (2) change in majority ownership applications submitted by a home health agency, and (3) change of information applications in which a new entity or individual (e.g., owner, managing employee, corporate director) is being added in section 5 or 6.

15.5.7 – Chain Organizations

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section only applies to the Form CMS-855A.)

All providers that are currently part of a chain organization or are joining a chain organization must complete section 7 with information about the chain home office. Under 42 CFR §421.404, a “home office” means the entity that provides centralized management and administrative services to the providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services. Other definitions relevant to chain organizations (and which are in § 421.404) include:

- Chain provider - A group of two or more providers under common ownership or control.
- Common control - Exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.
- Common ownership – Exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

The contractor shall not delay its processing of the provider’s application while awaiting the issuance of a chain home office number (i.e., a determination as to whether a set of entities qualifies as a chain organization). Such an issuance/determination is not required for a recommendation for approval.

In addition, the contractor shall ensure that:

- The chain home office is identified in section 5A and that final adverse action data is furnished in section 5B. (For purposes of provider enrollment, a chain home office automatically qualifies as an owning/managing organization.) Note that a National Provider Identifier (NPI) is typically not required for a chain home office.

- The chain home office administrator is identified in section 6A and that final adverse action data for the administrator is furnished in section 6B. (For purposes of provider enrollment, a chain home office administrator is automatically deemed to have managing control over the provider.)

For more information on chain organizations, refer to:

- Pub. 100-04, chapter 1, sections 20.3 through 20.3.6
- 42 CFR §421.404
- CMS change request 5720

15.5.8 – Billing Agencies

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(Unless otherwise stated, this section applies to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, and the Form CMS-20134.)

A billing agency is an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services. In order to receive payment directly from Medicare on behalf of a provider or supplier, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act.

The provider shall complete section 8 of the Form CMS-855 or Form CMS-20134 with information about all billing agents it utilizes. As all Medicare payments must be made via electronic funds transfer, the contractor need not verify the provider's compliance with the "Payment to Agent" rules in CMS Publication 100-04, chapter 1, section 30.2. The only exception is if the contractor discovers that the "special payments" address in section 4 of the provider's Form CMS-855 or Form CMS-20134 application belongs to the billing agent or agency. In this situation, the contractor may obtain a copy of the billing agreement if it has reason to believe that the arrangement violates the "Payment to Agent" rules.

If the chain organization listed in section 7 of the Form CMS-855A also serves as the provider's billing agent, the chain must be listed in section 8 as well.

For further information on billing agencies, see CMS Publication 100-04, chapter 1, section 30.2.4.

15.5.9 – Special Requirements for MDPP Suppliers: Section 7 of Form CMS-20134

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background Information

Only organizations, and not individuals, are eligible to enroll as an MDPP supplier. However, MDPP services are furnished to Medicare beneficiaries by MDPP coaches in group settings. Though these individuals furnish MDPP services on behalf of MDPP suppliers, only the MDPP supplier itself enrolls in Medicare. To enable CMS to better ensure the integrity of the program and the safety of the beneficiaries it serves, MDPP suppliers are required to report identifying information of coaches on their enrollment application, in section 7 of the Form CMS-20134. If a coach is being added or changed, the updated information must be reported via a Form CMS-20134 change request

B. Coach Eligibility and Screening

As indicated Section 15.4.6.4, the MDPP supplier standards indicate that MDPP suppliers may not include on their roster or allow MDPP services to be furnished by an ineligible coach. CMS indicates that, to furnish MDPP services to a beneficiary, an MDPP coach must not:

- Currently have Medicare billing privileges revoked and be currently subject to a reenrollment bar.
- Currently have its Medicaid billing privileges terminated for-cause or be excluded by a State Medicaid agency.
- Currently be excluded from 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.
- Currently be debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.
- Have, in the previous 10 years, one of the following State or Federal felony convictions:
 - Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
 - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the

individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.

- Any felony that placed the Medicare or its beneficiaries at immediate risk, such as a malpractice suit that results in the individual being convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion of criminal neglect or misconduct.
- Any felonies for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion that would result in mandatory exclusion under section 1128(a) of the Act.

Upon enrollment or any changes to Section 7 of the Form CMS-20134 that results in a new coach being added, Medicare Contractors are to confirm that the coach is not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management (SAM) (formerly, the General Services Administration Excluded Parties List System) and, to the extent possible, whether or not an individual coach meets the above eligibility criteria. Should the contractor identify that an ineligibility criteria has been met as a result of that screening, but have questions as to whether it would qualify as meeting an ineligibility criteria, they should contact PEOG.

If a coach is being added or changed, the updated information must be reported via a Form CMS-20134 change request.

C.. Coach Eligibility Start and End Dates

MDPP coaches may be expected to have a high turnover rate. To document which coaches are active with a supplier at a given time, each coach will have an eligibility start and, if applicable, an eligibility end date.

For each change to section 7 of the Form CMS-20134, the MDPP supplier must indicate a date of such change. For changes that result in a coach being added, either from an initial enrollment or a change of information to add a new coach to the MDPP supplier's roster, the date of the change becomes the coach's eligibility start date. Dates may be post-dated into the future. MDPP supplier may also include eligibility start dates in the past. However, per, 42 CFR 424.205(d), MDPP suppliers must report all changes to the coach roster within 30 days of such a change. Thus, if an MDPP supplier adds a coach with an effective date more than 30 days prior to the date of the supplier is making the change, the Contractor shall revoke the MDPP supplier under 42 CFR 424.530(a)(1) for non-compliance with the MDPP supplier standards. For example, if the MDPP supplier is already enrolled and on May 1, 2018 submits a change of information to add a new coach, but indicates its eligibility start date as March 1st, the MDPP supplier would not be complying with MDPP supplier standards. In this scenario, the Contractor may develop to obtain the correct effective date on the application.

If the Contractor determines the coach to be ineligible, the coach's eligibility start and end date shall be documented as the same date, therefore the coach was never eligible. Coaches may also get eligibility end dates if the MDPP supplier removes that coach from their roster. In this case, the eligibility end date would be the date the MDPP supplier indicated when they updated Section 7 to remove the coach. Similarly to eligibility start dates, an MDPP supplier may include a date that is within 30 days in the future or 30 days in the past of the date they are making the change. The contractor may return the application if the start date is more than 30 days in the future. Lastly, a coach may also receive an eligibility end date if the MDPP supplier to which they are associated is revoked or does not revalidate its enrollment. In this scenario, the coach's eligibility end date is the same date as the date the MDPP supplier's billing privileges were no longer effective.

An MDPP supplier may only be paid for services furnished by eligible coaches within their eligibility start and end dates.

D. Consequences for Coach Ineligibility

If Medicare contractors or CMS directly determines that an MDPP supplier has an ineligible coach on its roster, then the MDPP coach would be non-compliant with the MDPP supplier standards, and would have their enrollment denied or revoked, as appropriate under 424.430(a)(1) or 424.435(a)(1). As with existing procedures, MDPP suppliers would have the opportunity to submit a corrective action plan (CAP) removing this coach from its roster within 30 days of receiving notice of its enrollment denial or revocation, and, if compliant, could maintain their Medicare enrollment.

In this case, MDPP suppliers need not submit any additional documentation, however, they must update section 7 of the Form CMS-20134 to remove the ineligible coach. No further documentation is necessary.

E. Special Revocation for Knowingly Using an Ineligible Coach

While MDPP supplier standards indicate that MDPP suppliers may not include ineligible coaches on its roster or allow them to furnish MDPP services on their behalf to Medicare beneficiaries, it does not prohibit the MDPP supplier to continue to employ or allow the coach to volunteer for other services unrelated to MDPP. Should CMS identify that an MDPP supplier is knowingly allowing an ineligible coach to continue furnishing MDPP services, the MDPP supplier would be revoked under a new revocation authority at §424.205(h)(5), and any other revocation authority that may apply.

In this context, knowingly means that the MDPP supplier received an enrollment denial or revocation notice based on failing to meet the standard specified in §424.205(d)(3), was provided notice by CMS or contractors working on its behalf of this coach's ineligibility including the reason(s) for ineligibility, submitted

a CAP to remove the coach, then became compliant once again and maintained its enrollment, but continued to allow the ineligible coach removed from Section 7 of the Form CMS-20134 to provide MDPP services in violation of the CAP.

Further details are outlined in 15.27.3.C.

15.5.10 – Reserved for Future Use

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

15.5.11 – Reserved for Future Use

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

15.5.12 – Special Requirements for Home Health Agencies (HHAs)

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section only applies to the Form CMS-855A.)

A. Capitalization

For initial applications, the contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR §489.28. (Note that capitalization need not be reviewed for revalidation or reactivation applications.) The contractor may request from the provider any and all documentation deemed necessary to perform this task. Failure to meet the capitalization requirements shall result in a denial or revocation, as appropriate. For more information on HHA capitalization, see §489.28 and section 15.26.2 of this chapter.

B. Nursing Registries

If the HHA checks “yes” in section 12B, the contractor shall ensure that the information furnished about the HHA nursing registry is accurate. (A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

15.5.13 – Contact Persons

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless stated otherwise in this chapter or in another CMS directive - or unless the provider requests that the contractor communicate with only a specific individual (e.g., an authorized official) or via specific means (e.g., only via the correspondence address email) - the contractor has the discretion to use the contact persons listed in section 13 of the Form CMS-855 or CMS-20134 for all written and oral communications (e.g., mail, email, telephone) related to the provider’s Medicare enrollment. Such communication need not be restricted to a particular enrollment application of the provider’s that the contractor is currently processing. Nor is the contractor required (again, unless either CMS or the provider directs otherwise) to

send certain materials to the correspondence mailing or email address rather than the contact person's mailing or email address.

The provider may have as many contact persons as it wishes. If multiple contact persons are listed, the contractor has the discretion to select the individual to contact unless the provider indicates otherwise via any means. In addition:

- The contractor may use multiple contact persons throughout the enrollment process; it need not use the same individual for the entire duration unless, again, the provider indicates otherwise.
- All contact persons shall be stored in PECOS and shall not be removed unless the provider requests the removal via letter, email, or fax. Currently there is no option on the CMS-855 or CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 or CMS-20134 form.
- If the contractor discovers that a particular contact person qualifies as an owning or managing individual, the contractor shall develop to the provider to determine if the person should be listed in section 6 of the application.
- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

15.5.14 – Certification Statement Signature Requirements

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

Unless otherwise specified, the instructions in sections 15.5.14 through 15.5.14.5 apply to: (1) signatures on the paper Form CMS-855 or paper Form CMS-20134, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures.

All handwritten signatures are valid and appropriate in regards to (1) signatures on the paper Form CMS-855 or paper Form CMS-20134, (2) uploaded signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications.

15.5.14.1 - Form CMS-855I and CMS-855O Signatories

(Rev. 689, Issued: 12-09-16, Effective: 01-09-17, Implementation: 01-09-17)

The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I or the Form CMS-855O. (This applies to initial enrollments, changes of information, reactivations, revalidations, voluntary withdrawals, etc.) This includes solely-owned entities listed in section 4A of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I or Form CMS-855O on his/her behalf to any other person.

Note: Exceptions to the above policy may apply in the following scenarios: (1) in the case of death, an executor of the estate, may sign on behalf of the deceased provider, or (2) if an employer is terminating an employment arrangement with a physician assistant, the Authorized or Delegated Official of the organization may sign the application. These situations would only apply to change of information applications.

15.5.14.2 - Form CMS-855R Signatories

(Rev. 689, Issued: 12-09-16, Effective: 01-09-17, Implementation: 01-09-17)

For Form CMS-855R initial applications, the certification statement must be signed and dated by the physician or non-physician practitioner and the authorized official or delegated official of the provider or supplier.

For Form CMS-855R applications submitted to change and/or update the provider or supplier's Medicare enrollment data, to include updates to the primary practice location or termination of a reassignment, the certification statement may be signed by either the physician or non-physician practitioner or the authorized or delegated official of the provider or supplier.

15.5.14.3 - Form CMS-855A, Form CMS-855B, and Form CMS-20134 and Form CMS-855S Signatories

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

For Form CMS-855A, CMS-855B, CMS-855S, and CMS-20134 initial applications, the certification statement must be signed and dated by an authorized official of the provider or supplier. (See section 15.1.1 and 15.5.14.3.1 of this chapter for a definition of "authorized official.").

For Form CMS-855A, CMS-855B, CMS-855S, and CMS-20134 applications submitted to change, update and/or revalidate the provider or supplier's Medicare enrollment data, the certification statement may be signed and dated by the authorized or delegated official of the provider or supplier.

15.5.14.3.1 - Authorized Officials

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(Unless indicated otherwise below or in another CMS directive, the instructions in this section apply to (1) signatures on the paper Form CMS-855 or Form CMS-20134, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures. (**NOTE:** This section only applies to the Form CMS-855A, the Form CMS-855B, and the Form CMS-20134.))

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider with the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in 42 CFR 424.510. This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

If an authorized official is listed as a "Contracted Managing Employee" in section 6 of the Form CMS-855 or Form CMS-20134 and does not qualify as an authorized official under some other category in section 6, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is not listed as a "Contracted Managing Employee" in section 6 and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

In addition:

1. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.
2. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.
3. Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an

authorized official, and (2) section 6 of the Form CMS-855 or Form CMS-20134 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

4. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 or Form CMS-20134 should be the date of signature.

5. Social Security Number - To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

6. Identifying the Provider – As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

7. An authorized official is an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. An AO is not restricted to the examples of the titles outlined above but is applicable to an equivalent that is an appointed official to whom the organization has granted the legal authority to act on behalf of the organization. These additional titles could include, but are not limited to, executive directors, administrator, president, vice president. Contractors shall consider the individual's title as well as the authority granted by the organization when determining whether an individual qualifies as an AO when processing enrollment applications. If the contractor is unsure of an AO's qualifications or authority, they shall contact their provider enrollment Business Function Lead (BFL) for further clarification.

15.5.14.3.2 – Delegated Officials

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A delegated official is an individual to whom an authorized official listed in section 15 of the Form CMS-855 or Form CMS-20134 delegates the authority to report changes and updates to the provider's enrollment record or to sign revalidation applications. The delegated official's signature binds the organization both legally and financially, as if the signature was that of the authorized official. Before the delegation of authority is established, the only acceptable signature on the enrollment application to report updates or changes to the enrollment information is that of the authorized official currently on file with Medicare. The delegated official must be an individual with an "ownership or control interest" in (as that term is defined in §1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- Someone with a partnership interest in the provider, if the provider is a partnership

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's delegated official.

The contractor shall note the following about delegated officials:

1. Authority - A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.
2. Section 6 – Section 6 of the Form CMS-855 and CMS-20134 must be completed for all delegated officials.
3. Managing Employees - For purposes of section 16 only, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2

employees. For instance, suppose the provider hires Joe Smith as an independent contractor to run its day-to-day-operations. Under the definition of "managing employee" in section 6 of the Form CMS-855, Smith would have to be listed in that section. Yet under the section 16 definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under section 16 of the Form CMS-855 or CMS-20134.

4. W-2 Form – Unless the contractor requests it to do so, the provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

5. Number of Delegated Officials - The provider can have as many delegated officials as it chooses. Conversely, the provider is not required to have any delegated officials. Should no delegated officials be listed, the authorized official(s) remains the only individual(s) who can report changes and/or updates to the provider's enrollment data.

6. Effective Date - The effective date in PECOS for section 16 of the Form CMS-855 or Form CMS-20134 should be the date of signature.

7. Social Security Number - To be a delegated official, the person must have and must submit his/her social security number. An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.

8. Deletion - If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. Also, the signature of the deleted official is not needed.

9. Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare data or to sign revalidation applications.

10. Delegated Official Not on File - If the provider submits a change of information (e.g., change of address) and the delegated official signing the form is not on file, the contractor shall ensure that (1) the person meets the definition of a delegated official, (2) section 6 of the Form CMS-855 or Form CMS-20134 is completed for that person, and (3) an authorized official signs off on the addition of the delegated official. (**NOTE:** The original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.)

11. Signature on Paper Application - If the provider submits a paper Form CMS-855 or Form CMS-20134 change request, the contractor may accept the signature of a

delegated official in Section 15 or 16 of the Form CMS-855, or Form CMS-20134, as appropriate.

15.5.14.4 – Submission of Paper and Internet-based PECOS Certification Statements

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. Paper Submissions

A signed certification statement shall accompany the paper CMS-855 application and CMS-20134. If the provider submits an invalid certification statement or fails to submit a certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 15.5.14.1; (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider’s application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- The certification statement may be returned via scanned email or fax.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider’s authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.
- For paper changes of information applications (as the term “changes of information” is defined in section 15.6.2 of this chapter), if the

certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.

- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official's signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver's license or passport to verify a signature.

B. Internet-based PECOS Submissions

If the provider submits its application online and chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality. The provider shall not mail in its paper certification statement as it will not be accepted. Unless stated otherwise in this chapter or in another CMS directive:

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.
- Signature dates cannot be prior to 120 days of the receipt date of the application.
- If the provider submits an invalid certification statement, the contractor shall treat this as missing information and develop for a correct certification statement – preferably via email or fax. This includes certification statements that are: (a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 15.5.14.1; (e) missing certification statements, or (f) stamped. The contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. The contractor may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation.
- For Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that

must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.

- For Internet-based PECOS changes of information applications (as the term “changes of information” is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.
- The contractor is not required to compare the signature thereon with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person. The contractor shall not request the submission of a driver’s license or passport to verify a signature.

15.5.14.5 – Certification Statement Development

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

If the provider submits an invalid certification statement (e.g., unsigned; undated; or stamped signature; signed more than 120 days of the receipt date, incorrect individual signed it; not all authorized officials signed it) or neglects to send a certification statement, the contractor shall treat this as missing information and develop for a correct certification statement using the procedures outlined in this chapter. The contractor shall send a development letter to the provider – preferably via email or fax.

Any development requests that require the submission of a newly-signed certification statement, may be submitted by the provider via scanned email, fax or mail (paper applications only). Only the actual signature page is required; the additional page containing the certification terms need not be submitted. This also applies to the provider’s initial submission of a certification statement; such instances require the submission of only the signature page and not the certification terms.
the submission of only the signature page and not the certification terms.

15.5.15 – Reserved for Future Use

(Rev. 689, Issued: 12-09-16, Effective: 01-09-17, Implementation: 01-09-17)

15.5.15.1 – Form CMS-855I Signatories

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I. (This applies to initial enrollments, changes of information, reactivations, etc.) This includes solely-owned entities listed in section 4A of the Form CMS-855I. A physician or non-physician practitioner may not

delegate the authority to sign the Form CMS-855I on his/her behalf to any other person.

15.5.15.2 – Form CMS-855A and Form CMS-855B, and Form CMS-20134 Signatories

(Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

For Form CMS-855A, CMS-855B, and CMS-20134 initial applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 15.1.1 of this chapter for a definition of “authorized official.”) The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. Section 6 of the Form CMS-855 or Form CMS-20134 must be completed for each authorized official.

If an authorized official is listed as a “Contracted Managing Employee” in section 6 of the Form CMS-855 or CMS-20134 and does not qualify as an authorized official under some other category in section 6, he/she cannot be an authorized official.

The contractor shall notify the provider accordingly. If the person is not listed as a “Contracted Managing Employee” in section 6 and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider’s parent company, management company, or chain home office as a basis for his/her role as the provider’s authorized official.

In addition:

1. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official’s signature, or (2) documentation verifying that the person is no longer an authorized official.
2. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes

and/or updates to the provider's enrollment data or to sign revalidation applications.

3. Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) section 6 of the Form CMS-855 or Form CMS-20134 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.
4. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 or Form CMS-20134 should be the date of signature.
5. Social Security Number - To be an authorized official, the person must have and must submit his/her social security number (SSN). An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.
6. Identifying the Provider – As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.
7. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a

newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. This applies to the provider's initial submission of a certification statement for a particular application as well; such instances do not require the submission of both the signature page and the page containing the certification terms.

15.5.16 – Supporting Documents

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Documentation of the provider/supplier's TIN is required with the CMS-855 in the following scenarios; initial enrollment, the addition of an EIN to a sole proprietor's enrollment record, a change of legal business name, and in any instance the contractor identifies a discrepancy between an application and/or CMS-588 EFT submission and the provider/supplier's enrollment record. The contractor does not need to develop otherwise.

When documentation of the provider's or supplier's TIN and/or LBN is required, the contractor may accept a CP-575, a federal tax department ticket, or any other pre-printed document from the IRS that identifies the TIN and/or LBN.

15.5.17 – Supporting Documents for MDPP Suppliers - Recognition Status

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

In addition to the information reported in Section 2 of the Form CMS-20134, MDPP suppliers must also submit any reporting documents as required, see 15.5.16 and Section 17 of the Form CMS-20134 for more information, as well as documentation to verify the organization's recognition status.

As outlined in 15.4.6.4, MDPP suppliers must have MDPP Preliminary recognition or full recognition, as determined by CMS.

A. Supporting Documents for MDPP Preliminary recognition

Per 42 CFR 424.205(c)(1), MDPP preliminary recognition may include either a preliminary recognition established by CDC for the purposes of the DPRP or an MDPP interim preliminary recognition. MDPP interim preliminary recognition means a status that CMS has granted to an entity. Thus, an organization with MDPP preliminary recognition may submit supporting document – likely a notification letter of enrollment status from either CMS or CDC. Contractors shall verify supporting documents with what was submitted in Section 2 of the Form CMS-20134, and any other documentations provided by CMS, including lists of organizations with MDPP interim preliminary recognition. The Contractor shall:

- Verify that any letter has appropriate letterhead from either CDC or CMS, and that the letter indicates that the organization has met preliminary recognition with an effective date within a year of the application
- Verify that the organization code on the application matches both the organization code on the letter as well as either CDC's online registry or any list provided by CMS for those with interim preliminary recognition
- Verify that the CDC's online registry or any list provided by CMS indicates that the entity associated with that organizational code has met MDPP preliminary recognition
- Verify that name associated with the organizational code on the list is consistent with the name that is listed in the supporting documentation.

B. Supporting Documents for Full CDC Recognition

Organizations with full CDC recognition must submit a copy of its recognition certificate provided by CDC. To verify the applicant's eligibility, the Contractor shall:

- Verify that the submitted certificate reflects that the organization has met full recognition with an effective date within a year of the application
- Verify that the organization code on section 2 of the Form CMS-20134 matches both the organization code on CDC's online registry and on the certificate.
- Verify that CDC's online registry indicates that the entity associated with that organizational code has met full recognition
- Verify that name associated with the organizational code on CDC's online registry is consistent with what is listed on the certificate, as well as what is provided in Section 2 of the Form CMS-20134

15.5.20 – Processing Form CMS-855R Applications

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Information

A Form CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, (2) terminate an existing reassignment, or (3) update the primary practice location listed on the Form CMS-855R.

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a Form CMS-855I as well as a Form CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a Form CMS-855B or, if applicable, a Form CMS-855A. (See section 15.7.6 for additional instructions regarding the joint processing of Form CMS-855As,

Form CMS-855Rs, Form CMS-855Bs, and Form CMS-855Is.)

Benefits are reassigned to a provider or supplier, not to the practice location(s) of the provider or supplier. As such, the contractor shall not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location.

An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the Form CMS-855I. Here, the only forms that are necessary are the Form CMS-855R and separate Form CMS-855Is from the reassignor and the reassignee. (No Form CMS-855B or Form CMS-855A is involved.) The reassignee himself/herself must sign section 6B of the Form CMS-855R, as there is no authorized or delegated official involved.

The contractor shall follow the instructions in Pub. 100-04, chapter 1, sections 30.2 – 30.2.16 to ensure that a physician or other provider or supplier is eligible to receive reassigned benefits.

B. Reassignment to Entities that Complete the Form CMS-855A

Consistent with 42 CFR §424.80(b)(1) and (b)(2) and Pub. 100-04, chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7, Medicare may pay: (1) a physician or other provider or supplier's employer if the provider or supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other provider or supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are met. For example, on the Part A side, this might occur with (1) a physician or other provider or supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital billing under Method II (Critical Access Hospital (CAH) II) or (2) a nurse practitioner reassigning to a CAH II.

If the entity receiving the reassigned benefits is not a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

If the entity receiving the reassigned benefits is a CAH II, the entity need not and should not complete a separate Form CMS-855B form to receive reassigned benefits. The physician/practitioner can reassign benefits directly to the CAH II's Part A enrollment. The distinction between CAHs billing Method I vs. Method II only applies to outpatient services; it does not apply to inpatient services.

Under Method I:

- The CAH bills for facility services
- The physicians/practitioners bill separately for their professional services

Under Method II

- The CAH bills for facility services
- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service
- If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

Although eligible physicians or non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs).

In this scenario, the Forms CMS-855I and CMS-855R shall be submitted to the Part B MAC and the Form CMS-855A to the Part A MAC. The Part B MAC shall be responsible for reassigning the individual to the Part A entity.

The reassignment to the Part A entity shall only occur if the Form CMS-855A for the CAH II has been finalized. This can be determined by viewing PECOS to identify if an approved enrollment exists for the CAH II. If one does not, the Part B MAC shall return the Form CMS-855I and/or Form CMS-855R to the provider. If an enrollment record exist but is in an Approved Pending RO Review status, the Part B MAC shall contact the Part A MAC to determine if the tie-in notice has been received from the RO but not yet updated in PECOS, prior to returning the applications.

C. Ambulatory Surgical Centers (ASCs) and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR §424.80, and Pub. 100-04, chapter 1, sections 30.2.6 and 30.2.7, may reassign their benefits to an ASC.

If a physician or non-physician practitioner wishes to reassign its benefits to an existing (that is, a currently-enrolled) ASC, both the individual and the entity must sign the CMS-855R. However, it is not necessary for the ASC to separately enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

D. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of his/her own practice, employs another physician (the "employed physician/practitioner") to work with him/her, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole

owner die or have his/her billing privileges revoked, and the provider or supplier fails to submit an updated CMS-855 within 90 days, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the enrollments for both shall be deactivated in accordance with the deactivation procedures outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a professional corporation, a professional association, or a solely-owned limited liability company.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides deactivating the enrollments of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

- (1) The practice's enrollments have been deactivated;
- (2) Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death or date of revocation or deactivation will not be paid; and

(3) If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper Form CMS-855 application) a Form CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 15.5.20(C)(3) only, submission of a (1) complete Form CMS-855I application as an initial enrollment and (2) a terminating Form CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

E. Miscellaneous Reassignment Policies

1. A Form CMS-855R is required to terminate a reassignment. The termination cannot be done via the Form CMS-855I (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment).
2. The authorized or delegated official who signs section 6 of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(s) CMS-855A or CMS 855B, Form CMS-855I, and Form CMS-855R - the person must be listed on the CMS-855A or CMS-855B as an authorized or delegated official.
3. If the Form CMS-855R is accompanied by an initial Form CMS-855I or submitted as a "stand-alone" form (that is, a Form CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in section 15.17 of this chapter.

4. The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

5. In situations where the provider or supplier is both adding and terminating a reassignment, each transaction must be reported on a separate Form CMS-855R. The same Form CMS-855R cannot be used for both transactions.

6. The Form CMS-855R application shall not be used to:

- Report employment arrangements of physician assistants (PAs); employment arrangements for PAs must be reported on the Form CMS-855I.
- Revalidate reassignments; the individual practitioner should only use the Form CMS-855I and list his or her active reassignment information in section 4B thereof.
- Go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending> to view the CMS-855R Processing Guide, which constitutes a general Form CMS-855R processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855R, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855R applications.

F. Reassignment Termination Effective Date

When approving a Form CMS-855R to terminate a reassignment, the contractor shall enter an effective date of termination in PECOS as the day after the day listed on the application. For example: a physician submits a CMS-855R to terminate a reassignment to a group and lists June 30, 2019 as the date of termination. The effective date of the termination listed in PECOS and any correspondence to the provider should be July 1, 2019.

15.5.20.1 – Inter-Jurisdictional Reassignments

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. General Policy

If a physician/NPP (reassignor) is reassigning his or her benefits to an entity (reassignee) located in another contractor jurisdiction – a practice that is permissible - the following principles apply:

1. The reassignor must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location. The practice location can be an office or even the individual's home (for example, a physician interprets test results in his home for an independent diagnostic testing facility).

2. The reassignor need not – pursuant to the reassignment - enroll in the reassignee’s contractor jurisdiction nor be licensed/authorized to practice in the reassignee’s state. If the reassignor will be performing services within the reassignee’s state, the reassignor must enroll with the Medicare contractor for – and be licensed/authorized to practice in – that state.

3. The reassignee must enroll in the contractor jurisdictions in which (1) it has its own practice location(s), and (2) the reassignor has his or her practice location(s). In Case (2), the reassignee:

- Shall identify the reassignor’s practice location as its practice location on its Form CMS-855B
- In Section 4A of its Form CMS-855B shall select the practice location type as “Other health care facility” and specify “Telemedicine location.”
- Need not be licensed/authorized to perform services in the reassignor’s state.

To illustrate, suppose Dr. Smith is located in Contractor Jurisdiction X and is reassigning his benefits to Jones Medical Group in Contractor Jurisdiction Y. Jones must enroll with X and with Y. Jones need not be licensed/authorized to perform services in Dr. Smith’s state. However, in Section 4 of the Form CMS- 855B it submits to X, Jones must list Dr. Smith’s location as its practice location.

B. Applicability

The term "reassignee," as used in section 15.5.20.1(A), includes any provider or supplier that is permitted to bill and receive payment under a reassignment, in accordance with existing Medicare policy.

15.6 - Timeliness and Accuracy Standards

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Sections 15.6.1 through 15.6.3 of this chapter address the timeliness and accuracy standards applicable to the processing of Form CMS-855, Form CMS-20134 applications and opt-out affidavits. Even though the provisions of 42 CFR §405.818 contain processing timeframes that differ than those in sections 15.6.1 through 15.6.3, the contractor shall adhere to the standards specified in sections 15.6.1 through 15.6.3.

The processing of an application or opt-out affidavit generally includes, but is not limited to, the following activities:

- Receipt of the application or opt-out affidavit in the contractor’s mailroom and forwarding it to the appropriate office for review.
- Prescreening the application or opt-out affidavit.
- Creating a logging and tracking (L & T) record and an enrollment or opt-out affidavit record in the Provider Enrollment, Chain and Ownership System (PECOS).
- Ensuring that the information on the application or opt-out affidavit is verified.
- Requesting and receiving clarifying information.
- Site visit (if necessary).
- Formal notification to the SA and/or RO of the contractor’s approval, denial or recommendation for approval of the application.

15.6.1 – Standards for Initial and Revalidation Applications and Opt-Out Affidavits

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

For purposes of sections 15.6.1.1 through 15.6.1.4 of this chapter, the term “initial applications” also includes:

1. Form CMS-855 or Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the new owner.
2. “Complete” Form CMS-855 or Form CMS-20134 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), (c) as a Form CMS-855 or Form CMS-20134 reactivation, or (d) as a revalidation.
3. Reactivation certification packages (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter).
4. Opt-out affidavits submitted for an eligible practitioner’s first opt-out period.

Initial and revalidation application and opt-out affidavit timeliness standards shall be reported together. Likewise, initial and revalidation and opt-out affidavit accuracy shall be reported together.

**15.6.1.1 - Paper Applications and Opt-Out Affidavits - Timeliness
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

For purposes of sections 15.6.1.1.2 through 15.6.1.1.4 below, the term “development” means that the contractor needs to contact the supplier for additional information. (A prescreening letter to the provider is considered to be the first developmental request.)

15.6.1.1.1 – Form CMS-855 and Form CMS-20134 Applications That Require a Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 80 percent of all Form CMS-855 and Form CMS-20134 initial and revalidation applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 and Form CMS-20134 initial and revalidation applications that require a site visit within 150 calendar days of receipt, and process 95 percent of all Form CMS-855 and Form CMS-20134 initial and revalidation applications that require a site visit within 210 calendar days of receipt.

15.6.1.1.2 – Form CMS-855 and Form CMS-20134 Applications That Do Not Require a Site Visit and Opt-Out Affidavits

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The contractor shall process 80 percent of all Form CMS-855 and Form CMS-20134 initial and revalidation applications that do not require a site visit and opt-out affidavits within 60 calendar days of receipt, process 90 percent of all Form CMS-855 and Form CMS-20134 initial and revalidation applications that do not require a site visit and opt-out affidavits within 120 calendar days of receipt, and process 95 percent of all Form CMS-855 and Form CMS-20134 initial and revalidation applications that do not require a site visit and opt-out affidavits within 180 calendar days of receipt.

**15.6.1.2 - Paper Applications and Opt-Out Affidavits – Accuracy
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

The contractor shall process 98 percent of paper CMS-855 and Form CMS-20134 initial and revalidation applications and opt-out affidavits in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 15.6.1.1.1 through 15.6.1.1.4 of this chapter) and all other applicable CMS directives.

15.6.1.3 - Web-Based Applications - Timeliness

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 90 percent of Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications within 45 calendar days of receipt, process 95 percent of Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications within 60 calendar days of receipt, and process 99 percent of Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.
- Verification of the application in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.
- Supplier site visit (if required).

**15.6.1.3.1 – Web-Based Applications That Require a Site Visit
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

The contractor shall process 80 percent of all Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications that require a site visit within 90 calendar days of receipt, and process 95 percent of all Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications that require a site visit within 120 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.
- Verification of the application in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.
- Supplier site visit.

**15.6.1.3.2 – Web-Based Applications That Do Not Require a Site Visit
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

The contractor shall process 80 percent of all Form CMS-855 and Form CMS-

20134 Web-based initial and revalidation applications that do not require a site visit within 45 calendar days of receipt, process 90 percent of all Form CMS-855 Web-based initial and revalidation applications that do not require a site visit within 60 calendar days of receipt, and process 95 percent of all Form CMS-855 Web-based initial and revalidation applications that do not require a site visit within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.
- Verification of the application in accordance with existing instructions.
- Requesting and receiving clarifying information in accordance with existing instructions.

15.6.1.4 - Web-Based Applications - Accuracy

Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 98 percent of Form CMS-855 and Form CMS-20134 Web-based initial and revalidation applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 15.6.1.3 above) and all other applicable CMS directives.

15.6.2 – Standards for Changes of Information

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

For purposes of timeliness, the term “changes of information” also includes:

1. Form CMS-855 and Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the old owner
2. Form CMS-588 changes submitted without a need for an accompanying complete Form CMS-855 or Form CMS-20134 application
3. Form CMS-855R applications submitted independently (i.e., without being part of a Form CMS-855I or Form CMS-855B package)
4. Form CMS-855 and Form CMS-20134 voluntary terminations
5. Opt-out early termination requests (of initial opt-out affidavits), changes of information and cancellation requests

15.6.2.1 - Paper Applications and Opt-Out Changes of Information - Timeliness

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The contractor shall process 80 percent of paper Form CMS-855 and Form CMS-20134 changes of information and opt-out early termination requests, changes of information and cancellation requests within 60 calendar days of receipt, and process 95 percent of paper Form CMS-855 and Form CMS-20134 changes of information and opt-out early termination requests, changes of information and cancellation requests within 120 calendar days of receipt. This process generally includes, but is not limited to, the following activities:

- Receipt of the change or opt-out termination request, cancellation request, or other change of opt-out information in the contractor's mailroom and forwarding it to the appropriate office for review.
 - Prescreening the change request in accordance with existing instructions.
 - Creating an L & T record and, if applicable, tying it to an enrollment or opt-out affidavit record in PECOS.
 - Verification of the change request in accordance with existing instructions.
 - Requesting and receiving clarifying information in accordance with existing instructions.
 - Supplier site visit (if necessary).
- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary).

15.6.2.2 - Paper Applications and Opt-Out Changes of Information - Accuracy

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The contractor shall process 98 percent of paper Form CMS-855 and Form CMS-20134 changes of information and opt-out early termination requests, changes of information and cancellation requests in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 15.6.2.1 above) and all other applicable CMS directives.

15.6.2.3 - Web-Based Applications - Timeliness

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 90 percent of all Form CMS-855 and Form CMS-20134 Web-based change of information applications within 45 calendar days of receipt, and process 95 percent of all such changes of information within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review. (This obviously does not apply to applications submitted with an electronic signature.)
- Ensuring that the changed information has been verified
- Requesting and receiving clarifying information
- Supplier site visit (if necessary)
- Formal notification to the SA and/or RO of the contractor's approval, denial or recommendation for approval of the application.

15.6.2.4 - Web-Based Applications – Accuracy (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall process 98 percent of Form CMS-855 and Form CMS-20134 Web-based change of information applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 6.2.3 above) and all other applicable CMS directives.

15.6.3 - General Timeliness Principles (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless stated otherwise in this chapter or in another CMS directive, the principles discussed below apply to all applications discussed in sections 15.6.1 through 15.6.2.3 of this chapter (e.g., change of ownership (CHOW) applications submitted by old and new owners, CMS-588 forms).

A. Clock Stoppages

The processing time clocks identified in sections 15.6.1 and 15.6.2.3 of this chapter cannot be stopped or suspended for any reason. This includes, but is not limited to, the following situations:

- Referring an application to the Office of Inspector General (OIG) or the Zone Program Integrity Contractor.
- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).
- Waiting for the regional office (RO) to make a provider-based or CHOW determination.
- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number.

- Contacting CMS' Provider Enrollment & Oversight Group (PEOG) or an RO's survey/certification staff with a question regarding the application or CMS policy.

Notwithstanding the prohibition on clock stoppages and suspensions, the contractor should always document any delays by identifying when the referral to CMS, the OIG, etc., was made, the reason for the referral, and when a response was received. By doing so, the contractor will be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. To illustrate, assume that a contractor received an initial Form CMS-855I application on March 1. On March 30, the contractor sent a question to CMS, and received a reply on April 7. The processing time clock did not stop from March 31 to April 7. However, the contractor should document its files to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

B. Calendar Days

Unless otherwise stated in this chapter, all days in the processing time clock are "calendar" days, not "business days." If the 60th day (for initials) or 45th day (for changes of information) falls on a weekend or holiday, this is still the day by which the application must be processed. If the contractor is unable to finish processing the application until the next business day, it should document the file that the 60th day fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

C. Date-Stamping

As a general rule, all incoming correspondence must be date-stamped on the day it was received in the contractor's mailroom. This includes, but is not limited to:

- Any Form CMS-855 or Form CMS-20134 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)
- Letters from providers. (The first page of the letter must be date-stamped.)
- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)
- Data that the provider furnishes (via mail or fax) per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application. Thus, it is necessary to determine the sequence in which the application and the additional pages were received.)

For applications that do not require the submission of an fee, the timeliness clock

begins on the date on which the application/envelope is date-stamped in the contractor's mailroom, not the date on which the application is date-stamped or received by the provider enrollment unit. As such, the date-stamping activities described in the above bullets must be performed in the contractor's mailroom. In cases where the mailroom staff fails to date-stamp a particular document, the provider enrollment unit may date-stamp the page in question. However, there shall not be long lapses between the time it was received in the mailroom and the time the provider enrollment unit date-stamped the pages.

In addition, and unless stated otherwise in this chapter or in another CMS directive, all incoming enrollment applications (including change requests) must be submitted via mail.

D. When the Processing Cycle Ends

For (1) Form CMS-855A applications, and (2) Form CMS-855B applications submitted by ambulatory surgical centers (ASCs) or portable x-ray suppliers, the processing cycle ends on the date that the contractor:

- Sends its recommendation of approval to the State agency
- Denies the application

In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the State or RO), the cycle ends on the date that the contractor sends notification to the provider that the change has been processed. If notification to the provider is made via telephone, the cycle ends on the date that the telephone call is made (e.g., the date the voice mail message is left).

For (1) Form CMS-855I applications, (2) Form CMS-855R applications, (3) Form CMS-855B applications from suppliers other than ASCs and portable x-ray suppliers, and (4) Form CMS-20134 applications the processing cycle ends on the date that the contractor sends its approval/denial letter to the supplier. For change request approval/denial notifications made via telephone, the cycle ends on the date that the telephone call is made (e.g., the date the voice mail message is left).

For any application that is rejected per existing instructions, the processing time clock ends on the date that the contractor sends notification to the provider that the application has been rejected.

E. PECOS

Unless stated otherwise in this chapter or in another CMS directive, the contractor must create a logging & tracking (L & T) record in PECOS:

- For applications that do not require an application fee, no later than 20

calendar days after its receipt of the provider's application in the contractor's mailroom.

- For applications that require an application fee, no later than 20 calendar days after:
 - The date on which the provider paid the fee – as confirmed by either the Fee Submitter List or the provider's submission of a receipt of payment from Pay.gov, or
 - The date on which PEOG approved the provider's hardship exception request (or, for suppliers of durable medical requirement, prosthetics, orthotics and supplies, the date on which the NSC approved the hardship exception request).

Moreover, the contractor must establish a complete enrollment record in PECOS – if applicable - prior to its approval, recommendation of approval, or denial of the provider's application. To the maximum extent possible, the contractor shall establish the enrollment record at one time, rather than on a piecemeal basis.

The L & T and enrollment record requirements in the previous paragraph apply to all applications identified in sections 15.6.1 through 15.6.2.4 of this chapter (e.g., reassignments, CHOW applications submitted by old and new owners).

In situations where the contractor cannot create an L & T record within 20 days due to missing information (e.g., no NPI was furnished), the contractor shall document the provider file accordingly.

15.7 – Application Review and Verification Activities (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless stated otherwise in this chapter or in another CMS directive:

(A) The instructions in sections 15.7 through 15.7.1.6.2 apply to:

- The Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, Form CMS-855O, and Form CMS-20134.
- All Form CMS-855 transaction types identified in this chapter (e.g., changes of information, reassignments).

(B) Except for situations where a “processing alternative” applies (see sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter) or unless stated otherwise in this chapter or in another CMS directive, the contractor shall:

- Ensure that the provider has completed all required data elements on the Form CMS-855 (including all effective dates) or Form CMS-20134 and that all supporting documentation has been furnished. The contractor shall also

ensure that the provider has completed the application in accordance with the instructions (1) in this chapter and in all other CMS directives and (2) on the Form CMS-855 or Form CMS-20134. (The instructions on the Form CMS-855 and Form CMS-20134 shall be read and applied in addition to, and not in lieu of, the instructions in this chapter and all other applicable CMS directives.)

- Verify and validate all information furnished by the provider on the Form CMS-855 or Form CMS-20134.

(C) The instructions in sections 15.7 through 15.7.1.6.2 are in addition to, and not in lieu of, all other instructions in this chapter.

In general, the application review and verification process is as follows:

1. Contractor receives application
2. Contractor reviews application and verifies data thereon
3. If (a) required data/documentation is missing, (b) data cannot be verified, and/or (3) there are data discrepancies, contractor requests missing/clarifying information from the provider.
4. If applicable, contractor (a) verifies any newly furnished data, or (2) seeks additional data/clarification from provider.
5. Final determination

Sections 15.7.1 through 15.7.1.6.2 are structured so as to generally follow Steps 2 through 5 above.

15.7.1 – Receipt/Review of Application and Verification of Data (Rev. 525, Issued: 06-27-14, Effective: 07-29-14, Implementation; 07-29-14)

The contractor is no longer required to pre-screen provider enrollment applications.

15.7.1.1 – Receipt/Review of Paper Applications (Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

A. Background

The contractor shall begin processing the application upon application receipt. This includes, but is not limited to (and subject to the processing alternatives in sections 15.7.1.3.1 through 15.7.1.3.4):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted
- Submitted a valid and dated certification statement signed by an appropriate individual (e.g., the enrolling physician for Form CMS-855I applications)
- Validating all data on and submitted with the application, provided that a data source is available,
- Entering all information contained on the application into the Provider Enrollment, Chain and Ownership System(PECOS).

The contractor may begin the verification process at any time. Also, the contractor is not required to create a PECOS logging and tracking (L & T) record within a certain specified timeframe (e.g., within 20 days after receipt of the application).

B. Other Guidelines

1. Acknowledgment of Receipt of Application – The contractor may, but is not required to, send out acknowledgment letters or emails.
2. “Not Applicable” – Unless a “processing alternative” applies, the provider cannot write “N/A” in response to a question that requires a “yes” or “no” answer. This is considered an incomplete reply, thus warranting the issuance of a request for missing information.
3. Unsolicited Submission of Information - If the provider submits missing/clarifying data or documentation on its own volition (i.e., without being contacted by the contractor), the contractor shall include this additional data/documentation in its overall application review.
4. Reenrollment Bar – If the contractor suspects that a provider or supplier is attempting to circumvent an existing reenrollment bar by enrolling under a different business identity or as a different business type, the contractor shall contact CMS’ Provider Enrollment Business Function Lead (PEBFL) for guidance.
5. State and Country of Birth – The state of birth and country of birth are optional data elements on the Form CMS-855. As such, the contractor shall not develop for this information if it was not disclosed on the application and shall not request other contractors to update the PECOS Associate Control (PAC) ID to include this data.

6. Photocopying Pages - The contractor may accept photocopied pages in any Form CMS-855 or Form CMS-20134. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the Form CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers.

7. White-Out & Highlighting - The contractor shall not write on or highlight any part of the original Form CMS-855 or Form CMS-20134 application or any supplementary pages the applicant submits (e.g., copy of license). Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be resubmitted.

15.7.1.2 – Receipt/Review of Internet-Based PECOS Applications (Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

A. Background

1. The provider shall submit their certification statement via e-signature or PECOS upload to their contractor. See section 15.5.14.4 for further instructions on certification statement submissions.

2. Switch to “In Review” and Application Returns

If the provider fails to submit or has submitted an invalid certification statement, the contractor shall still proceed with processing the application. An appropriate certification statement shall be solicited as part of the development process. If the certification statement was a) unsigned; (b) undated; (c) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (d) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in section 15.5.14.1; (e) missing certification statements, or (f) stamped, the contractor shall send one development request to include a list of all of the missing required data/documentation, including the certification statement. If the provider fails to furnish the missing information on the enrollment application, including all necessary documentation, the contractor shall reject the provider's application, if the conditions for rejection exist per section 15.8.2.

In order to develop for missing certification statements, MACs shall enter the current date in the Logging and Tracking number certification statement field in the PECOS if the certification statement date is missing.

Once the above step is complete, the contractor shall: (1) enter the date of signature in the “Certification Date” box in the logging & tracking (L & T)

record, and (2) change the L & T status to “In Review.”

If the contractor can determine (without having yet begun processing the application) that an application can be returned under section 15.8.1 of this chapter (e.g., Form CMS-855I was submitted more than 60 days prior to the effective date), the contractor shall return the application without waiting for the arrival of the certification statement.

B. Processing of Application

After tasks (1) and (2) above have been completed, the contractor shall begin processing the application. Subject to the processing alternatives in sections through 15.7.1.3.4, processing includes (but is not limited to):

- Ensuring that all required data elements on the application have been completed and that all required supporting documentation has been submitted (either via paper or the Digital Data Repository (DDR))
- Validating all data on and submitted with the application, provided that a data source is available

15.7.1.3 – Verification of Data/Processing Alternatives (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Verification - General

1. Means of Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify and validate – via the most cost-effective methods available - all information furnished by the provider on or with its application. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 or Form CMS-20134 is accurate.

Examples of verification techniques include, but are not limited to:

- Site visits
- Third-party data validation sources
- State professional licensure and certification Web sites (e.g., medical board sites)
- Federal licensure and certification Web sites (if applicable)

- State business Web sites (e.g., to validate “doing business as” name)
- Yellow Pages (e.g., to verify certain phone numbers)

The list of verification techniques identified in this section 15.7.1.3 is not exhaustive. If the contractor is aware of another means of validation that is as cost-effective and accurate as those listed, it is free to use such means. However, all Social Security Numbers (SSNs) and National Provider Identifiers (NPIs) listed on the application will continue to be verified through PECOS. The contractor shall not request an SSN card to verify an individual’s identity or SSN.

2. Procedures

Unless stated otherwise in this chapter or in another CMS directive, the following principles apply:

(1) A data element is considered “verified” when, after attempting at least one means of validation, the contractor is confident that the data is accurate. (The contractor shall use its best judgment when making this assessment.)

(2) The contractor need only make one verification attempt (i.e., need only use one validation technique) before either:

(a) Requesting clarifying information (as described in sections 15.7.1.4 through 15.7.1.6.2) if the data element cannot be verified. (However, the contractor is encouraged to make a second attempt using a different validation means prior to requesting clarification.)

OR

(b) Concluding that the furnished data is accurate.

3. Concurrent Reviews

If the contractor receives multiple Form CMS-855s or Form CMS-20134s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial Form CMS-855As for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider’s file that a single verification check was made for all four applications.

For purposes of this requirement: (1) there must be an organizational, employment, or other business relationship between the entities, and (2) the applications must have been submitted within a few weeks of each other. As an illustration, assume

that Group Practice A submits an initial Form CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because: (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related.

4. Contacting Other Contractor

During the verification process, the contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating circumstances.

B. Processing Alternatives

Sections 15.7.1.3.1 through 15.7.1.3.4 outline special processing rules ("processing alternatives") that are intended to reduce the burden on contractors and providers while simultaneously maintaining the integrity of the enrollment process. These provisions take precedence over all other instructions outlined in this chapter 15.

15.7.1.3.1 – Processing Alternatives – Form CMS-855B and Form CMS-855I

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855B and the CMS-855I, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-855 application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855 page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855, even if the data is identified elsewhere on the form or in the supporting documentation:

- a. Any final adverse action data requested in sections 3, 4A (Form CMS-855I only), 5B (Form CMS-855B only), and 6B of the Form CMS-855
- b. All ownership and managing control information in section 5A and 6A of the Form CMS-855B

- c. The applicants legal business names (LBN) or legal names
Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop. (This also applies to Employer's Name for PA's in section 2E of the Form CMS-855I)
- d. Tax identification numbers (TIN)
- e. NPI-legacy number combinations in Section 4 of the Form CMS-855
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
- f. Supplier/practitioner type (section 2A of the Form CMS-855B and section 2D of the Form CMS-855I)

2. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school Web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms described above. The contractor shall not develop for a correction to the form if the license information can be verified as described above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.
- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

3. City, State, and ZIP Code - If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the “zip + four” from either the U.S. Postal Service or the address validation in PECOS.

4. Inapplicable Questions - The supplier need not check “no” for questions that obviously do not apply to its supplier type. For instance, a nurse practitioner need not check “no” to question 1(a) in Section 2C of the Form CMS-855I.

5. Clinical Laboratory Improvement Act (CLIA) and Drug Enforcement Agency (DEA) - CLIA and DEA certificates need not be submitted if the applicable CLIA and DEA information was furnished on the Form CMS-855. Likewise, if the aforementioned certificates are furnished but the applicable Form CMS-855 sections are blank, no further development is needed.

6. Practice Locations - Each practice location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person’s verification shall be documented in the provider file pursuant to section 15.7.3 of this chapter.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1 (Form CMS-855B and Form CMS-855I)

With the exception of: (1) the voluntary termination checkbox, (2) the effective date of termination, and (3) physician assistant and reassignment data in section 1A of the Form CMS-855I, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

a. Form CMS-855B

- All information in section 2B1 (with the exception of the TIN and LBN) can be captured by telephone, fax, email, or Web site.
- If the contractor is aware that a particular state does not require licensure/certification and the “Not Applicable” boxes are not checked in section 2A2, no further development is needed.

b. Form CMS-855I

- If blank, “Type of Other Name” and “Gender” can be captured orally.
- If the contractor is aware that a particular state does not require licensure/certification and the “Not Applicable” boxes are not checked in section 2A, no further development is needed.
- In section 2D1, if the supplier uses a checkmark, an “X,” or other symbol to identify his/her primary and secondary specialties (as opposed to a “P” or “S”), no additional development is needed.
- When processing a non-physician practitioner’s (NPP) application, the contractor need not automatically request a copy of the NPP’s degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.
- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information is disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. Section 4

a. Form CMS-855B

- In section 4A, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, or fax.
- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier’s intentions. If the “special payments” address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855.
- In section 4E, if the “Check here” box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier’s intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-855.
- In section 4F, if the vehicle certificates are furnished but the applicable Form CMS-855 sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the supplier has.

b. Form CMS-855I

- If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
- In section 4C, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor; the contractor can confirm the information via telephone, email or fax.
- In section 4E, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4E must be completed via the Form CMS-855.

4. Section 8 (Form CMS-855B and Form CMS-855I) - If the telephone number is blank, the number can be verified with the supplier by telephone, email or fax. If the section is blank, including the check box, no additional development is necessary.

5. Section 13 (Form CMS-855B and Form CMS-855I)

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).
- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).
- Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

6. Section 15 (Form CMS-855I) Section 15 and 16 (Form CMS-855B)

The telephone number can be left blank. No further development is needed.

7. Attachment 1 (Form CMS-855B)

- In section D, the “Land,” “Air,” and “Marine” boxes need not be checked (or developed) if the type of vehicle involved is clear.
- Contractors are not required to develop for the written statement from the supplier, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility.

8. Attachment 2 (Form CMS-855B)

In section E, the telephone number of the supervising physician can be left blank. No further development is needed.

C. Supporting Documents

If the supporting documentation currently exists in the provider’s file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification.

Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.3.2 – Processing Alternatives – Form CMS-855A

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855A, unless otherwise specified:

1. Information Disclosed Elsewhere – If a data element on the provider’s Form CMS-855A application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855A page and a newly-signed certification statement; no further

development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855A, even if the data is identified elsewhere on the form or in the supporting documentation:

- a. Any final adverse action data requested in sections 3, 5B and 6B of the Form CMS-855A
- b. All ownership and managing control information in section 5A and 6A of the Form CMS-855A
- c. All legal business names (LBNs)(e.g., provider, chain home office)
Note: If an application is submitted with a valid NPI and OSCAR combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855A and the contractor is able to confirm the correct LBN based on the NPI and OSCAR combination provided, the contractor is not required to develop.
- d. All tax identification numbers (TINs)(e.g., provider, owning organization)
- e. NPI-legacy number combinations in section 4 of the Form CMS-855A
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
- f. Provider type
- g. The following data in sections 2F, 2G and 2H:
 - “Doing business as” name
 - Effective dates of sale/transfer/consolidation
 - Checkbox in section 2F indicating whether seller will accept assets/liabilities
 - Names of units with separate legacy numbers/NPIs;
 - All NPIs and legacy numbers
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the OSCAR or NPI before developing to the provider.

2. Licenses - In situations where the provider is required to submit a copy of a particular professional or business license, certification, or registration but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirmation pages from the applicable state web site, (2) requesting and receiving from the appropriate state body written confirmation of the provider’s status therewith, and (3) using any other third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, or

registration but fails to complete the appropriate section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

- The above-referenced written confirmation from a state body of the provider's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.
 - This exception only applies to those documents that traditionally fall within the category of licenses, registrations, or certifications. It does not apply to items such as adverse action documentation, bills of sale, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed.
3. City, State, and ZIP Code - If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of (1) the voluntary termination checkbox and (2) the effective date of termination, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- Other than the TIN and the LBN, all information in section 2B1 can be captured by telephone, email, fax, or a Web site.
- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes in section 2B2 are not checked, no further development is needed.
- With respect to sections 2F, 2G, and 2H, if the old/new owner's current contractor is not listed, the contractor can research this data on its own or obtain it from the provider by any means.

3. Section 4

- In section 4A, if the “type of practice location” checkbox is blank, the contractor can confirm the information via email or fax.
- In section 4B, if neither box is checked and no address is provided, the contractor can contact the provider by telephone, email, or fax to confirm the provider’s intentions. If the provider replies that the “special payments” address is the same as the practice location, no further development is needed. If, however, the provider wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855A.
- In section 4D, if the “Check here” box is not checked and no address is provided, the contractor can contact the provider by telephone, email or fax to confirm the provider’s intentions. If the provider replies that the base of operations address is the same as the practice location, no further development is needed. If the provider indicates that the base of operations is at a different location, the address in 4D must be completed via the Form CMS-855A.
- In section 4E, if the vehicle certificates are furnished but the applicable CMS-855A sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the provider has.

4. Section 7

- If all of section 7 is blank (including the check box just above section 7A), no additional development is necessary.
- If the provider indicates that it is part of a chain but the checkboxes in section 7A are blank, the contractor can verify the type of transaction involved via email or fax.
- In section 7B, if the person is also listed with complete information in section 6A (e.g., the individual’s Social Security Number (SSN) is listed in section 6A1), only the individual’s first and last name need be listed in section 7B.
- In section 7C, if the entity is also listed with complete information in section 5A, the company’s legal business name is the only data that must be listed in section 7C. (If blank, the cost report date, the home office’s contractor, and the chain number can be developed by phone, email, or fax.)
- If blank, data in section 7D can be collected by telephone, email or fax.
- If blank, data in section 7E can be collected by email or fax.

5. Section 8

- If the telephone number is blank, the number can be verified with the provider by telephone, email or fax.
- If all of section 8 is blank (including the check box), no additional development is necessary.

6. Section 12

- If it is obvious that the entity is not enrolling as a home health agency (HHA), the checkbox above section 12A can be left blank.
- If the entity is an HHA:
 - If section 12A1 or 12A3B is blank, the data can be verified by telephone, email, or fax.
 - If the telephone number in section 12B is blank, the number can be verified with the provider by telephone, email or fax.

7. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.
- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor may either (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.
- Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

8. Sections 15 and 16

The telephone number can be left blank. No further development is needed.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.3.3 – Processing Alternatives – Form CMS-855O (Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855O, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-855O application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855O page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855O, even if the data is identified elsewhere on the form or in the supporting documentation:

- a. Any final adverse action data requested in section 3
- b. Legal names
- c. Tax identification number (TIN)
- d. NPI-legacy number combinations in section 2 (if applicable)
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
- e. Data in section 1B

2. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school web site, (2) requesting and receiving from the appropriate state,

professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Likewise, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.
- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees such as adverse action documentation. Furthermore, the exception is moot in cases where a particular license/certification is not required by the state.

3. City, State, and ZIP Code - If a particular address lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

4. Drug Enforcement Agency (DEA) - DEA certificates need not be submitted if the applicable DEA information was furnished on the CMS-855. Similarly, if the aforementioned certificates are furnished but the applicable CMS-855 sections are blank, no further development is needed.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of the voluntary termination checkbox, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- If blank, "Type of Other Name" and "Gender" can be captured orally.
- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2C, no further development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.
- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information is disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. Section 4

If the supplier uses a checkmark, an "X," or other symbol to identify his/her primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

4. Section 6

If this section is completely blank, the contractor need not develop for this information and can simply contact the physician or practitioner.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.3.4 – Processing Alternatives – Form CMS-855R (Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

All data elements in sections 1, 2, 3, and 4 must be completed via the CMS-855R.

Regarding section 2:

- If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 2 of the Form CMS-855R, and

the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.

- MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the group/organization/individual that is receiving the reassigned benefits before developing to the provider for existing individual practitioners only. If information is missing from the 855R that cannot be verified in PECOS, the Shared Systems or provider files, then a development would have to be issued (i.e.: group information is missing from the 855R and not included in the 855I Section 4, this cannot be verified elsewhere).

Regarding section 3:

- MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the individual practitioner who is reassigning benefits before developing to the provider for existing individual practitioners only.

Regarding section 5:

- If this section is completely blank, the contractor need not develop for this information and can simply contact the party that submitted the form (e.g., the enrolling physician).
- If a contact person is listed, any other missing data (e.g., address, e-mail) can be captured via telephone.

15.7.1.3.5 - Processing Alternatives – Form CMS-20134 (Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing

The following general alternatives are applicable to all sections of the Form CMS-20134, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-20134 application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-20134 page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-20134, even if the data is identified elsewhere on the form or in the supporting documentation:

- a. Any final adverse action data requested in sections 3, 5B, and 6B

b. All ownership and managing control information in section 5A and 6A of the Form CMS-20134.

c. The applicants legal business names (LBN) or legal names

Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-20134 and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.

d. Tax identification numbers (TIN)

e. NPI-legacy number combinations in Section 4 of the Form CMS-20134

Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

f. Supplier/practitioner type in section 2A of the Form CMS-20134

1. Recognition Status

In situations where an MDPP supplier is required to submit a copy of its CDC recognition but fails to do so, the contractor need not obtain such documentation from the supplier if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the Centers for Disease Control and Prevention Web site, (2) requesting and receiving from the CDC written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the supplier submits a copy of the applicable recognition, but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the recognition itself or via any of the three mechanisms described above. The contractor shall not develop for a correction to the form if the recognition information can be verified as described above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

2. City, State, and ZIP Code - If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

3. Inapplicable Questions - The supplier need not check "no" for questions that obviously do not apply to its supplier type.

4. Administrative Locations - Each administrative location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in the provider file pursuant to section 15.7.3 of this chapter.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of: (1) the voluntary termination checkbox and (2) the effective date of termination, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- All information in section 2B1 (with the exception of the TIN and LBN) can be captured by telephone, fax, email, or Web site.

3. Section 4

- In section 4A, the type of location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, or fax.
- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the administrative location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-20134.
- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-20134.

4. Section 7

- If the date of change for an individual coach is completely blank, the contractor must develop for this information.

5. Section 8

- If the telephone number is blank, the number can be verified with the supplier by telephone, email or fax. If the section is blank, including the check box, no additional development is necessary.

6. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.
- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.
- Currently there is no option on the CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the Form CMS-20134.

7. Section 15 (Form CMS-855I) Section 15 and 16 (Form CMS-855B)

The telephone number can be left blank. No further development is needed.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.4 – Requesting Missing/Clarifying Data/Documentation

(Rev. 532, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

The procedures in sections 15.7.1.4.1 through 15.7.1.4.3 are subject to the processing alternatives identified in sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter.

15.7.1.4.1 – Paper Applications

(Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

If (1) the provider submits an application with at least one missing required data element, (2) the provider fails to submit at least one required document, (3) submits an invalid certification statement, or (4) the contractor determines that clarification is needed regarding certain information (e.g., particular data cannot be verified or there are data inconsistencies), the contractor shall send a development letter to the provider – preferably via email or fax - that contains, at a minimum, the applicable elements in (a) through (f) below. (See section 15.24 et seq. for model letters.)

(a) A list of all of the missing required data/documentation, an explanation of the certification statement's deficiencies, and/or the issues/information to be clarified.

(b) A request that the provider submits the missing data/documentation, clarification, and/or revised certification statement within 30 calendar days of the date of the request, as noted in the section 15.8.2 and in the examples found in section 15.7.1.5.

(c) Unless the only data that is missing is documentation, a request that the provider submit an appropriately signed and dated certification statement, which will cover both the submission of any missing data as well as any deficiencies associated with the original certification statement. The certification statement should be submitted by the provider via scanned email, fax or mail.

(A new certification statement is not required if the only missing material is documentation or if the clarification to be provided does not require any changes to the provider's Form-855 or Form CMS-20134 application.)

(d) If missing data is involved, the CMS Web site at which the CMS-855 forms and Form CMS-20134 can be found. The contractor shall instruct the provider to (1) print out the page(s) containing the missing data; (2) enter the data on the blank page; (3) sign and date a new, blank certification statement; and (4) send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.

(Step (d) is not needed if the only missing material is documentation.)

(e) An email address, fax number, and mailing address to which the missing/clarifying data/documentation/correct certification statement can be sent to the contractor.

(f) The name, phone number, and email address of a contact person at the contractor site.

15.7.1.4.2 – Internet-Based PECOS Applications

(Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

If the contractor determines that (1) required data/documentation are missing, (2) clarification is needed (e.g., certain data cannot be verified), and/or (3) the certification statement is invalid, the contractor should – after switching the L & T status to “Returned for Corrections” - send an email (via PECOS Internet) to the provider containing:

(a) A list of all missing data/documentation, information to be clarified, and/or certification statement issues;

(b) A request that the provider submit the data/materials in question within 30 calendar days of the date of the request, as noted in the section 15.8.2 and in the examples found in section 15.7.1.5; and

(c) The name, phone number, and email address of a contact person at the contractor site.

15.7.1.4.3 – General Principles – Paper and Internet-Based PECOS Applications

(Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

When requesting missing/clarifying information/documentation and/or or requesting a valid certification statement, the contractor shall adhere to the following:

A. Only One Request Needed – This is the only request the contractor must make. The contractor should, of course, respond to any of the provider’s telephone calls, emails, etc., resulting from the request. Yet the contractor need not – on its own volition – make an additional request unless the contractor uncovers missing data (or data that must be clarified) that it failed to detect prior to sending the original development letter.

To the extent possible, the contractor should avoid contacting the provider for missing/clarifying data/documentation until it has attempted to validate all of the data on the application. This will obviate the need to contact the provider each time the contractor discovers an issue.

B. Commencement of Timeframe – The 30-day clock referred to above commences on the day the contractor, as applicable: (1) mails, faxes, or emails the letter/request, or (2) sends the aforementioned Internet-based PECOS email.

C. Telephonic Requests

Unless otherwise stated in this chapter or in another CMS directive, telephonic requests for missing/clarifying data/documentation are generally not permitted for paper or Internet-based PECOS applications; it is important that requests for information or clarification be formalized in writing. However, in cases where CMS permits telephonic requests for such data, the contractor shall adhere to the following:

- A telephonic request is made when the contractor: (1) speaks with an appropriate provider official, or (2) leaves a message either with an appropriate official's staff (e.g., his/her executive assistant) or with an appropriate official's voice mail service. In situation (2), the contractor shall leave the name, telephone number, and email address of an appropriate individual at the contractor site who the official can contact; otherwise, the contact does not qualify as a legitimate request for clarification.

- When leaving a message, the contractor shall also state that the requested data/clarification must be furnished within 30 days.

- Telephone requests shall be made on weekdays between 9 am and 5 pm of the provider's time zone.

- The 30-day clock begins on the date (1) of the telephone conversation with the appropriate official, or (2) the message is left.

D. Inability to Contact Provider - If the contractor cannot, for the reasons listed below, communicate with the provider to request information/documentation, it shall attempt one alternative means of communication:

- The mailed letter is returned because the provider is not at that address

- The contractor cannot email the letter to the provider because of issues with the recipient's email system.

- The provider's fax number is repeatedly busy

If an alternative communication also cannot be completed for one of the above reasons, the contractor need not make another attempt to obtain the data and should reject the application once the applicable 30-day period expires. However, it is strongly advised that the contractor make a third attempt to contact the provider prior to taking this step, especially if it appears that the provider is otherwise acting

in good faith. (The contractor shall document each attempt to contact the provider.)

(With respect to email, an alternative communication includes sending an email to another listed contact person, delegated official, or authorized official.)

15.7.1.5 – Receiving Missing/Clarifying Data/Documentation (Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

The procedures in this section 15.7.1.5 are subject to the processing alternatives identified in sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter.

A. Requirement to Furnish All Missing/Clarifying Material

The provider must furnish all missing/clarifying data/documentation requested by the contractor within the 30-day timeframe. Whether the provider furnished all the information is a decision resting solely with the contractor. Should the provider furnish some (but not all) of the requested data/clarification within the specified time period, the contractor need not contact the provider again to request the remaining information. For instance, suppose the contractor requested missing data in sections 3, 4, and 5 of the Form CMS-855A. The provider only furnished the section 3 data. The contractor should reject the application without attempting another contact, per section 15.8.2.

For Internet-based PECOS applications, the provider shall upload its paper certification statement.

B. Format of Furnishing Missing Data

1. Paper Applications

Unless stated otherwise in this chapter or in another CMS directive, the provider shall: (1) provide the missing/clarification information (excluding documentation) on the applicable Form CMS-855 or Form CMS-20134 page(s) and (2) submit the missing material via mail, fax, or scanned email. A newly signed and dated certification statement must accompany the Form CMS-855 or Form CMS-20134 page(s) containing the missing data – unless the only missing information is supporting documentation, in which case no new certification statement is needed. The certification statement should be submitted by the provider via scanned email, fax or mail along with the missing information.

2. Internet-Based PECOS Applications

Unless stated otherwise in this chapter or in another CMS directive, the

provider should (1) submit the missing information by entering it into PECOS, (2) submit the missing documentation via fax, email, mail, or the Digital Data Repository (DDR), and/or (3) submit the certification statement via PECOS upload or e-signature. (The provider should submit the missing data via the applicable paper Form CMS-855 or Form CMS-20134 pages if it submitted its application via Internet-based PECOS). The certification statement should be submitted by the provider via scanned email or fax along with the missing information.

C. Format of Clarifying Data

In cases where clarifying (as opposed to missing) information is requested, the contractor should accept the clarification by email, fax, or letter. If the provider furnishes the clarification via telephone, the contractor shall – unless another CMS directive states otherwise - request that the provider furnish said clarification in writing (preferably via email).

If the provided clarification ultimately requires the provider to change or alter data that must be reported on the paper or Web Form CMS-855 or Form CMS-20134, the contractor shall instruct the provider via a follow-up email or fax to submit the revised data on the applicable Form CMS-855 or Form CMS-20134 page or via Internet-based PECOS and to furnish a new certification statement. The provider must submit the revised data and new certification statement within 30 days of the date of the original request for clarification (rather than 30 days from the date of the follow-up request to provide the data via the Form CMS-855 or Form CMS-20134). The certification statement should be submitted by the provider via scanned email or fax along with the missing information.

Consider the following illustrations:

EXAMPLE 1: The contractor notifies the provider via an emailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider emails the contractor on March 3 and explains the discrepancy. Based on this email, the contractor determines that the provider must correct its ownership data in section 5 of its Form CMS-855A. The contractor sends a follow-up email to the provider on March 7 instructing the provider to do so. The provider must submit the revised data on the Form CMS-855 (with a new certification statement) by March 31 (which is 30 days from the date of the original request, not April 6, or 30 days from the date of the follow-up email).

EXAMPLE 2: The contractor notifies the provider via emailed letter on March 1 of a discrepancy regarding its ownership information on the Form CMS-855A. The provider telephones the contractor on March 6 and explains the discrepancy to the contractor's satisfaction. Although the discrepancy

does not require the provider to make any revisions to its Form CMS-855A, the contractor shall request that the provider furnish its explanation in writing no later than 30 days from its March 1 email (or March 31, which is 30 days from the date of the original request), not 30 days from the date of its March 6 request for the written explanation.

EXAMPLE 3: The contractor notifies the provider via emailed letter on March 1 of a discrepancy regarding its ownership information on its paper Form CMS-855A. Determining (based on the contractor's email) that the ownership information it provided was incorrect, it submits a revised section 5 of its Form CMS-855A to the contractor with a new certification statement but without any accompanying explanation of the change (e.g., no accompanying letter or email). The contractor receives the revised section 5 on March 12. If the contractor determines that the discrepancy has been resolved via the revised submission, it is not required to contact the provider for an accompanying written explanation. (This is because the clarification was furnished in writing via the CMS-855 itself.) If, however, the contractor would like a written explanation or otherwise needs clarification about the submission, it should request that a written explanation be submitted no later than March 31 (which is 30 days from the date of the original request).

D. Maintenance of Received Material

The contractor shall maintain all missing/clarifying information or documentation received (including new certification statements) in the provider file. Storage can be electronic or via hard copy, but it must be in an otherwise easily accessible format.

15.7.1.6 – Failure to Submit Requested Data/Documentation (Rev. 532, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

The instructions in sections 15.7.1.6.1 and 15.7.1.6.2:

- Apply unless another CMS directive or instruction states otherwise.
- Are subject to the processing alternatives identified in sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter.

15.7.1.6.1 – Paper Applications (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

If, in the contractor's view, the provider failed to submit all of the requested data/documentation and/or a valid certification statement (either as a correction to the original certification statement or as part of a request for missing data), the contractor may:

- Reject the application if the 30-day period has elapsed,
- Wait until the 30-day period has elapsed and then reject the application, or
- Make a second request for the outstanding missing/clarifying data/documentation and/or an appropriate certification statement. (The request can be made via mail, fax, or email. If the request is sent via email, it need not be in the form of a letter.) The contractor may establish its own deadline for the provider's submission of the remaining data or the certification statement, though it must be at least 7 business days from the date of this second request. In making the request, the contractor must specify: (1) the date of the original request/development letter and the material that was requested therein; (2) the data that is still missing or must be clarified; (3) that a newly-signed certification statement is necessary if the data must be furnished on the Form CMS-855 or Form CMS-20134 (The certification statement may be submitted via scanned email, fax or mail along with the missing information); (4) the deadline for submission; (5) the address, fax number, and email address to which the data/certification statement can be sent; and (6) the name, phone number, and email address of an appropriate contact person at the contractor site.)

While the contractor is not required to make a second request if the provider fails to timely and fully respond to the development letter, the contractor is encouraged to make an additional request if: (1) it appears that the provider is making a good-faith effort to comply with the development letter and/or (2) the provider furnished most of the requested data. For instance, suppose the contractor requested 5 pieces of missing information. The contractor timely submitted 4 of them and furnished a signed (though undated) certification statement. Since the provider appears to be acting in good faith, the contractor is encouraged to continue working with the provider.

If the provider fails to fully respond to a second request, the contractor may either: (1) reject the application if the original 30-day period has elapsed, (2) wait until the 30-day period has elapsed and then reject the application, or (3) make a third request using the procedures described above.

15.7.1.6.2 – Internet-Based PECOS Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

If, in the contractor's view, the provider failed to submit all of the requested data/documentation and/or failed to submit a valid certification statement (either as a correction to the original certification statement or as part of a request for missing data), the contractor may:

- Reject the application if the 30-day period has elapsed,
- Wait until the 30-day period has elapsed and then reject the application, or

Make a second request for the outstanding missing/clarifying data/documentation and/or an appropriate certification statement. (The request shall be made via PECOS email.) The contractor can establish its own deadline for the provider's submission of the remaining data, though it must be at least 7 business days from the date of the request. In making the request, the contractor shall specify: (1) the date of the original development email and the material that was requested therein; (2) the data that is still missing or needs to be clarified; (3) that a newly-signed certification statement (either via Internet-based PECOS or paper. (The certification statement may be submitted by the provider via scanned email, fax or mail along with the missing material) is necessary if the data must be furnished on the Form CMS-855 or Form CMS-20134; (4) the deadline for submission; (5) the address, fax number, and email address to which the documentation or certification statement can be sent (though the provider should be encouraged to use e-signature and the DDR); and (6) the name, phone number, and email address of an appropriate contact person at the contractor site.

While the contractor is not required to make a second request if the provider fails to timely and fully respond to the development letter, the contractor is encouraged to make an additional request if: (1) it appears that the provider is making a good-faith effort to comply with the development letter and/or (2) the provider furnished most of the requested data.

If the provider fails to fully respond to a second request, the contractor may either: (1) reject the application if the original 30-day period has elapsed, (2) wait until the 30-day period has elapsed and then reject the application, or (3) make a third request using the procedures described above.

15.7.2 – Reserved for Future Use

(Rev. 525, Issued: 06-27-14, Effective: 07-29-14, Implementation; 07-29-14)

15.7.3 - Documentation

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 15.7.3. CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

The requirements in this section 15.7.3 are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

A. Written and Telephonic Communications

(For purposes of this section 15.7.3, “written correspondence” includes mailed, faxed, and e-mailed correspondence.)

1. Written Correspondence

The contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, State officials, etc.
- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in the file.
- Document all referrals to CMS, the ZPIC, or the OIG

2. Telephonic or Face-to-Face Contact (hereafter referred to as “oral communication”)

The contractor shall document any and all actual or attempted oral communication with the provider, any representative thereof, or any other person or entity regarding a provider. This includes, but is not limited to, the following situations:

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)
- Requesting information from the state or another contractor concerning the applicant or enrollee
- Contacting the ZPIC for an update concerning a particular case
- Phone calls from the provider
- Conducting a meeting at the contractor’s headquarters/offices with officials from a hospital concerning problems with its application
- Telephoning CO (e.g., CO’s provider enrollment unit) or the RO (e.g., the RO’s survey and certification staff) and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider
- Telephoning the provider’s billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate: (1) the time and date of the call or contact; (2) who initiated the contact; (3) who was spoken with; and (4) what the conversation pertained to. Concerning the last requirement,

the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation. The documentation can be crafted and stored electronically if the contractor can provide access within 24 hours upon request.

The documentation requirements in this subsection (A) only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

If an application is returned per section 15.8.1 of this chapter, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

B. Verification of Data Elements

Once the contractor has completed its review of the CMS-855 or Form CMS-20134 (e.g., approved/denied application, approved change request), it shall provide a written statement asserting that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the CMS-855 or Form CMS-20134 against the MED and the System for Access Management (SAM). The statement must be signed and dated. It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed. The record can be stored electronically.

For each person or entity that appeared on the MED or SAM, the contractor shall document the finding via a screen printout. In all other situations, the contractor is not encouraged to document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the verification statement is still required.

15.7.4 - Tie-In Notices

(Rev. 404, Issued: 01-20-12, Effective: 04-22-12, Implementation: 04-22-12)

Although it may vary by regional office (RO), tie-in and tie-out notices are generally issued in the following circumstances:

- Initial enrollment
- Change of Ownership (CHOW) under 42 CFR §489.18
- Acquisition/Merger
- Consolidation
- Addition or deletion of home health agency (HHA) branch, hospital unit, or

- outpatient physical therapy extension site
- Voluntary and involuntary termination of billing numbers

As each RO may have different practices for issuing tie-in and tie-out notices, the contractor should contact its RO to find out the specific circumstances in which such notices are issued. This also applies to instances where the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

In addition:

- **Approval Letters** – Depending on the RO, an approval letter may be issued in lieu of a tie-in notice.
- **Review for Consistency** - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the RO to determine why the data is different.
- **Receipt of Tie-In When CMS-855 Not Completed** - If the contractor receives a tie-in notice from the RO but the provider never submitted the necessary Form CMS-855 application, the contractor shall immediately alert the RO of the situation. The contractor shall also contact the provider and have it complete and submit the required application. (This applies to initial applications, CHOWs, practice location additions, etc.)
- **Creation of New Logging & Tracking (L & T) Record Unnecessary** - The contractor is not required to create a new L & T record in the Provider Enrollment, Chain and Ownership System when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

Note that 42 CFR §489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and (2) such requirements include the contractor's review and verification of an application to enroll in the Medicare program. (See sections 15.17.4 and 15.26.3 of this chapter for more information.)

15.7.5 – Special Program Integrity Procedures

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

This section contains additional verification procedures that the contractor shall utilize when processing the following transactions:

- Changes in the provider's practice location
- Change in the special payment address
- On the Form CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number

- Revalidations and Form CMS-855 or Form CMS-20134 Reactivations

The instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter and in other CMS directives. Also, unless otherwise stated, section 15.7.5 applies to the Form CMS-855A, Form CMS-855B, Form CMS-855I, and Form CMS-20134.

A. Change in Practice Location Address

In cases where a provider submits a Form CMS-855 or Form CMS-20134 request to change its practice location address, the contractor shall undertake the following activities:

1. Contact the location currently associated with the provider in the Provider Enrollment, Chain and Ownership System (PECOS) or the Multi-Carrier System (MCS) to verify that the provider is no longer there and did in fact move.

B. Change in Special Payments Address

If the provider submits a change to its special payments address, the contractor shall contact the individual physician/practitioner (for Form CMS-855I changes), an authorized or delegated official (for Form CMS-855A, Form CMS-855B, and Form CMS-20134 changes), or the contact person listed in section 13 (for Form CMS-855A, Form CMS-855B, Form CMS-20134, and Form CMS-855I changes) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

C. Change of EFT Information

If the provider submits a Form CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A, Form CMS-855B, and Form CMS-20134 enrollees), or the section 13 contact person on record (for Form CMS-855A, Form CMS-855B, Form CMS-20134, and Form CMS-855I enrollees) to verify the change. Hence, if the contractor cannot reach, as applicable,

the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

D. Revalidations and Form CMS-855 or Form CMS-20134 Reactivations

When processing a revalidation or Form CMS-855 or Form CMS-20134 reactivation application, the contractor shall – unless another CMS directive instructs otherwise - the contractor shall abide by the instructions in subsections A and B above, respectively, if the (a) practice location address or (b) special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS.

E. Reassignment of All Benefits

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, professional association, or limited liability company, the contractor shall call the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner.

F. Potential Identity Theft or Other Fraudulent Activity

In conducting the verification activities described in this section 15.7.5, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken.

15.7.5.1 – Special Procedures for Physicians and Non-Physician Practitioners

(Rev. 521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term “practitioner” includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

A. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

1. Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);
2. Otherwise lost their medical license or have had their licenses expire.

For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps to revoke the individual's billing privileges.

The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

B. Relocation to a New State

1. Licensure Reviews

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall review State licensing board information for the "prior" State to determine:

1. Whether the practitioner had his or her medical license revoked, suspended, or inactivated (due to retirement, death, or voluntary surrender of license), or otherwise lost his or her license, and
2. If the practitioner has indeed lost his or her medical license, whether he or she reported this information to Medicare via the CMS-855I within the timeframe specified in 42 CFR 424.520.

If the practitioner is currently enrolled and did not report the adverse action to Medicare in a timely manner, the contractor shall revoke the practitioner's Medicare billing privileges and establish a 1-year enrollment bar. If the practitioner is submitting an initial enrollment application (e.g., is moving to a new State and contractor jurisdiction) and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application and establish a 3-year enrollment bar.

2. Voluntary Withdrawal Reminder

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall determine whether the practitioner still has an active

PECOS enrollment record in the “other” State(s). If PECOS indeed indicates that the individual has an active practice location in the other State(s), the contractor shall remind the practitioner that if he/she no longer intends to practice in that State, he/she must submit a CMS-855 voluntary termination application to the contractor for that jurisdiction. The reminder should be given in the approval letter that the receiving contractor sends to the practitioner or, if more appropriate, in an e-mail or other form of written correspondence.

C. Break in Medical Practice

If the contractor receives a CMS-855I from a practitioner who was once enrolled in Medicare but who has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the State where the practitioner last worked whether the practitioner was convicted of a felony or had his or her license suspended or revoked. If such an adverse action was imposed, the contractor shall take action in accordance with the instructions in this chapter.

D. State Relationships

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

15.7.5.2 – Special Procedures for MDPP Suppliers

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

To help ensure that only qualified MDPP suppliers are enrolled in Medicare and only eligible coaches are interacting with MDPP beneficiaries, the contractor shall undertake the activities described below.

A. Recognition Status

CMS will notify any contractor when an MDPP supplier within their jurisdiction has moved from preliminary or full recognition down to pending, and therefore no longer maintains eligibility for an MDPP supplier.

For those suppliers that no longer have a valid recognition level to maintain their MDPP supplier enrollment, the contractor shall take the necessary steps to revoke the supplier’s billing privileges.

15.7.6 - Special Processing Guidelines for Form CMS-855A, Form CMS-855B, and Form CMS-855I Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall abide by the following:

- If an individual is joining a group that was enrolled prior to the Form CMS-855A or Form CMS-855B (i.e., the group or CAH II never completed a Form CMS-855), the contractor shall obtain a Form CMS-855A from the CAH II or Form CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group solely on the grounds that a Form CMS-855A or Form CMS-855B has not been completed. Once the group or CAH II's application is received, the contractor shall add the new reassignment; if the Form CMS-855R was not submitted, the contractor shall secure it from the provider or supplier.
- If a provider or supplier is changing its TIN, the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the provider or supplier must complete a full Form CMS-855 or Form CMS-20134 application and a new enrollment record must be created in PECOS. (This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a change of ownership is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)
- If the provider or supplier is adding or changing a practice location and the new location is in another state within the contractor's jurisdiction, the contractor shall ensure that the provider or supplier meets all the requirements necessary to practice in that State (e.g., licensure). A complete Form CMS-855 or Form CMS-20134 for the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new state.
- All members of a group practice must be entered into PECOS.

15.7.7 – Special Processing Guidelines for Form CMS-855A Applications

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless otherwise stated, all references to the "RO" in sections 15.7.7.1 through 15.7.7.7 of this chapter refer to the RO's survey & certification staff.

15.7.7.1 - Changes of Ownership (CHOWs)

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Changes of ownership (CHOWs) are officially defined in and governed by 42 CFR §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The RO – not the contractor – makes the determination as to whether a CHOW has

occurred (unless this function has been delegated).

Unless specified otherwise, the term “CHOW” - as used in sections 15.7.7.1 through 15.7.7.1.6 of this chapter - includes CHOWs, acquisitions/mergers and consolidations.

Though section 2 of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers and consolidations for ease of disclosing and reporting, they fall with the general CHOW category under 42 CFR §489.18 (e.g., an acquisition/merger is a type of CHOW under §489.18).

15.7.7.1.1 - Definitions

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the Form CMS-855A application:

- **“Standard” CHOW** – This occurs when a provider’s CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter’s purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A’s provider agreement and CCN number will transfer to B.

This is the most frequently encountered change of ownership scenario. As explained in section 15.7.7.1, even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the “CHOW” category – as opposed to the “Acquisition/Merger” category – on the Form CMS-855A.

- **Acquisition/Merger** - In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to merge. Entity B’s CCN number and provider agreement will be eliminated (leaving only Entity A’s CCN number and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in section 1A of the Form CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire Form CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported as a practice location in section 4 of the new owner’s Form CMS-855A.

- **Consolidations** - This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if

Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated. Entity C will have its own CCN number and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Under 42 CFR §489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Publication 100-07, chapter 3, section 3210.1D (4) for more information.)

Note that a provider may undergo a financial or administrative change that it considers to be a CHOW, but does not meet the regulatory definition identified in §489.18.

15.7.7.1.2 - Examining Whether a CHOW May Have Occurred (Rev. 499, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

As stressed in section 15.7.7.1, the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW may have occurred, and/or (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Such research may include reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. (A CHOW determination by the RO is usually not required prior to the contractor making its recommendation.)

While a CHOW is usually accompanied by a tax identification number (TIN) change, this is not always the case. There may be isolated instances where the TIN remains the same. Conversely, there may be cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, the contractor should review the sales/lease agreement closely, as this will help indicate whether a CHOW may or may not have occurred.

In addition:

(1) If the provider claims that the transaction in question is a stock transfer and not a CHOW, the contractor reserves the right to request any information from the provider to verify this (e.g., copy of the stock transfer agreement).

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the RO for guidance. Such referrals to the RO should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment may have taken place and should not be made as a matter of course. A RO CHOW determination is usually not required prior to the contractor making its recommendation.

(2) There may be instances where the contractor enters a particular transaction into the Provider Enrollment, Chain and Ownership System (PECOS) as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in the provider's file that the transaction was not a CHOW.

15.7.7.1.3 - Processing CHOW Applications

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless stated otherwise in this chapter, the contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owners are completed in accordance with the instructions on the Form CMS-855A.

A. Old Owners

The old owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the old owner's Form CMS-855A is available at the time of review, the contractor shall examine the information thereon against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the old owner's Form CMS-855A has not been received, the contractor shall contact the old owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the old owner's application. It may also make its recommendation to the State agency without having received the old owner's Form CMS-855A. The contractor, of course, shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and the terms of the sales agreement indicate as such.

If a certification statement is not on file for the old owner, the contractor shall request that section 6 be completed for the individual who is signing the certification statement.

Note that an old owner's Form CMS-855A CHOW application is essentially the

equivalent of a Form CMS-855 voluntary termination submission, as the seller is voluntarily leaving the Medicare program. As such, the contractor shall not require the seller to submit a separate Form CMS-855 voluntary termination along with its Form CMS-855A CHOW application.

B. New Owners

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's Form CMS-855A, the contractor shall contact the new owner. If the new owner fails to: (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the contractor contacted it, the contractor shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the contractor ascertains that the provider accepts assignment.

C. Order of Processing

To the maximum extent practicable, Form CMS-855A applications from the old and new owners in a CHOW should be processed as they come in. The contractor should not wait for applications from both the old and new owner to arrive before processing them. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the old and new applications to the State simultaneously, rather than as soon as they are processed. For instance, suppose the old owner submits an application on March 1. The contractor should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the old owner's application to the State until the new owner's application is processed. (For acquisition/mergers and consolidations, the contractor may send the applications to the RO separately, since one number is going away.)

D. Sales and Lease Agreements

The contractor shall abide by the following:

- **Verification of Terms** - The contractor shall determine whether: (1) the information contained in the sales/lease agreement is consistent with that reported on the new owner's Form CMS-855A (e.g., same names), and (2) the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in section 2F is checked "Yes" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should deny the application.

- **Form of Sales/Lease Agreement** - There may be instances where the parties in a CHOW did not sign a “sales” or “lease” agreement in the conventional sense of the term; the parties, for example, may have documented their agreement via a “bill of sale.” The contractor may accept this documentation in lieu of a sales/lease agreement so long as the document furnishes clear verification of the terms of the transaction.
- **Submission of Final Sales/Lease Agreement** - The contractor shall not forward a copy of the application to the State agency until it has received and reviewed the final sales/lease agreement. It need not revalidate the information on the Form CMS-855A, even if the data therein may be somewhat outdated by the time the final agreement is received.

If a final sales/lease agreement is not submitted within 90 days after the contractor’s receipt of the new owner’s application, the contractor shall reject the application. Though the contractor must wait until the 90th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were obtained.

Unless specified otherwise in this chapter, both the old and new owners must submit separate Form CMS-855A applications, as well as copies of the interim and final sales/lease agreements.

E. CHOWs Involving Subunits and Subtypes

Any subunit that has a separate provider agreement (e.g., home health agency (HHA) subunits) must report its CHOW on a separate Form CMS-855A. It cannot report the CHOW via the main provider’s Form CMS-855A. If the subunit has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the CHOW can be disclosed on the main provider’s Form CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity.

On occasion, a CHOW may occur in conjunction with a change in the facility’s provider subtype. This frequently happens when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital that undergoes a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.

F. Early Submission of CHOW Application

The contractor may accept Form CMS-855A CHOW applications submitted up to 90 calendar days prior to the anticipated date of the ownership change. Any application received more than 90 days before the projected sale date can be returned under section 15.8.1 of this chapter.

G. Unreported CHOW

If the contractor learns via any means that an enrolled provider has: (1) been purchased by another entity, or (2) purchased another Medicare enrolled provider, the contractor shall immediately request Form CMS-855A applications from both the old and new owners. If the new owner fails to submit a Form CMS-855A within the latter of: (1) the date of acquisition, or (2) 30 days after the request, the contractor shall stop payments to the provider. Payments may be resumed upon receipt of the completed Form CMS-855A.

If the contractor learns of the transaction via the receipt of a tie-in notice from the RO, it shall follow the instructions under “Receipt of Tie-In When CMS-855A Not Completed” in section 15.7.7.2 of this chapter.

H. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the provider shall - per CMS Publication 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

I. Transitioning to Provider-Based Status

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR §489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the “new contractor”) shall process both the buyer’s and seller’s Form CMS-855A applications. Should the “old” (or current) contractor receive the buyer’s or seller’s Form CMS-855A application, it shall: (a) forward the application to the new contractor

within 5 business days of receipt, and (b) notify the new contractor within that same timeframe that the application was sent.

15.7.7.1.4 - Intervening Change of Ownership (CHOW)
(Rev. 462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

(This section does not apply to home health agencies)

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the CMS Regional Office (RO), the contractor shall abide by the following:

- Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall return both applications and require the provider to re-submit an initial application with the new owner’s information.
- Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the State/RO in the same package. The accompanying notice/letter to the State/RO shall explain the situation.
- Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:
 - Return the CHOW application.
 - Notify the State/RO via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner’s information.
 - Request via letter that the provider submit a new initial CMS-855A application containing the new owner’s information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the initial application and notify the provider and the State/RO of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the State/RO with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted

application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

- Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:
 - Notify the State/RO via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the State/RO with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

15.7.7.1.5 – Electronic Funds Transfer (EFT) Payments and CHOWs

(Rev.717, Issued: 05-12-17, Effective: 05-15-17, Implementation: 05-15-17)

In a CHOW, the contractor shall continue to pay the Seller/Transferor until it receives the tie-in/approval notice from the RO. Hence, the contractor shall reject any application from the Seller or the Buyer to change the EFT account or special payment address to that of the new owner before receiving the tie-in/approval notice. It is ultimately the responsibility of the Buyer and the Seller to work out any payment arrangements between themselves while the contractor and RO are processing the CHOW. It is advisable that the contractor notify the new owner of this while the application is being processed.

In a CHOW, the existing provider agreement is automatically assigned to the Buyer/Transferee. If the Buyer/Transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will **never** pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the Buyer/Transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

15.7.7.1.6 – Pre-Approval Changes of Information

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a Form CMS-855 request to change any of the provider’s enrollment data, the contractor shall reject the change request if the information in question involves changing the provider’s:

1. Electronic funds transfer or special payment address information to that of the buyer (as described in section 15.7.7.1.5 of this chapter)
2. Practice location or base of operations to that of the buyer
3. Ownership or managing control to that of the buyer
4. Legal business name, tax identification number, or “doing business as” name to that of the buyer.

All other “pre-tie-in notice” Form CMS-855 change requests from the seller can be processed normally.

B. Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a Form CMS-855 request to change any of the provider’s existing enrollment information, the contractor shall reject the change request. Until the tie-in notice is issued, the seller remains the owner of record. Hence, the buyer has no standing to submit Form CMS-855 changes on behalf of the provider.

15.7.7.2 - Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev.717, Issued: 05-12-17, Effective: 05-15-17, Implementation: 05-15-17)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice (CMS-2007) is generally issued in the following circumstances:

1. Initial enrollments
2. CHOWs
3. Voluntary terminations
4. Involuntary terminations (e.g., provider no longer meets conditions of participation or coverage) prompted by the state/RO

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855 Changes of Information, Stock Transfers, and Other Transactions

1. Referrals to State/RO

The following is a list of Form CMS-855A transactions that generally require a recommendation and referral to the state/RO:

- Addition of outpatient physician therapy/outpatient speech pathology extension site
- Addition of hospice satellite
- Addition of home health agency branch
- Change in type of Prospective Payment System (PPS)-exempt unit
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Change in practice location or subunit address in cases where a survey of the new site is required
- Stock transfer

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to “approved” until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review,

approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

(1) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,

(2) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and

(3) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in (B)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved).

2. Post-Approval RO Contact Required

Form CMS-855A changes that do not mandate a recommendation to the state/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or hospital subunits
- Legal business name, tax identification number, or "doing business as name" changes that do not involve a CHOW
- Address changes that do not require a survey of the new location
- Addition of hospital practice location
- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials

- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

For these transactions, the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to “approved.” The contractor shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO shall specify the type of information that is changing.

3. All Other Changes of Information

For all Form CMS-855A change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the provider via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to “approved.” The state and RO need not be notified of the change.

4. Revalidations, Reactivations and Complete Form CMS-855 Applications

In situations where the provider submits a: (1) Form CMS-855A reactivation, (2) Form CMS-855A revalidation, or (3) full Form CMS-855A as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state/RO and switch the PECOS record to “approval recommended” only if the application contains new/changed data falling within one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855A, the contractor shall make a recommendation to the state/RO and await the RO’s approval before switching the record to “approved.” In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state/RO needs to consider is the new hospital unit.

If the application contains new/changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to “approved.” It shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

C. Provider-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice or approval letter from the RO for a transaction/change regarding information that is not collected on the Form CMS-855A, the contractor need not ask the provider to submit a Form CMS-855A change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider's Medicare participation because the provider no longer meets the conditions of participation, the contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the provider's/supplier's enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall **not** identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."

In addition, contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar. If CMS learns that the terminated provider plans to receive further surveys during the reasonable assurance period, then CMS will rescind the enrollment bar. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

E. Other Procedures Related to Tie-In Notices, Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855A Not Completed - If the contractor receives a tie-in notice or approval letter from the RO but the provider never completed the necessary Form CMS-855A, the contractor shall have the provider complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency – There may be instances when the RO delegates the task of issuing tie-in notices, tie-out notices or approval letters to the state agency. The contractor may accept such notices from the state in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the state, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

3. Review for Consistency - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855A. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

4. Creation of New Logging and Tracking (L & T) Record Unnecessary - The contractor is not required to create a new L & T record in PECOS when the tie-in notice arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Provider Inquiries – Once the contractor has made its recommendation for approval to the state/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the state or RO.

6. Timeframes - So as not to keep the PECOS record in “approval recommended” status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

15.7.7.2.1 – Processing Tie-In Notices/Approval Letters (Rev. 433, Issued: 09-07-12, Effective: 10-09, 12, Implementation 10-09-12)

With respect to Form CMS-855A transactions for which a post-tie-in notice/approval letter site visit is not required (e.g., providers in the “limited” risk category), the contractor shall complete its processing of said notice/letter within 21 calendar days after its receipt of the tie-in/approval notice. For purposes of this requirement, the term “processing” includes all steps taken by the contractor’s enrollment and non-enrollment units (e.g. financial area, reimbursement area) to establish the provider’s ability to bill Medicare such as, but not limited to:

1. Entering all relevant data into the Provider Enrollment, Chain and Ownership System (PECOS).
2. Changing the provider’s PECOS record to the appropriate status (e.g., “approved”).
3. Facilitating the provider’s electronic funds transfer and electronic data interchange arrangements.
4. Notifying the provider (via any mechanism the contractor chooses) that it may begin billing.

The 21-day period begins on the day that the contractor receives the tie-in notice and ends on the day that the contractor notifies the provider that it can commence billing.

Regarding Form CMS-855A transactions that require a post-tie-in notice/approval letter site visit, the contractor shall process the tie-in notice/letter within 45 calendar days of its receipt of the notice/letter. This is to account for the additional time needed for the site visit to be performed.

15.7.7.3 - Reserved for Future Use

(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)

15.7.7.4 - State Surveys and the Form CMS-855A

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

In general, information on the Form CMS-855A is still considered valid notwithstanding a delay in the State survey. However, the provider must submit an updated Form CMS-855A application to the contractor if:

- The contractor becomes aware of such a delay;
- The delay is the fault of the provider; and
- At least 6 months have passed since the contractor sent its recommendation for approval to the State.

If these criteria are met, the contractor shall send a letter to the provider requesting an updated Form CMS-855A. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the provider may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed Form CMS-855A certification statement.

NOTE: If the applicant is a home health agency (HHA), it must resubmit capitalization data per section 12 of the Form CMS-855A regardless of whether any of the provider's other Form CMS-855A information has changed. To illustrate, if no Form CMS-855A data has changed, the HHA must submit the letter, capitalization data and the signed certification statement.

If the provider fails to furnish the requested information within 60 days of the contractor's request, the contractor shall submit a revised letter to the State that recommends denial of the provider's application.

15.7.7.5 - Sole Proprietorships

(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

If the provider indicates in section 2B1 of the Form CMS-855A that he/she is a sole proprietor, the contractor shall note the following:

- The LBN in section 2B1 should list the person's (the sole proprietor's) legal name.
- The TIN in section 2B1 should list the person's social security number.

- Section 3 of the Form CMS-855A must be completed with information about the individual's final adverse action history.
- Section 5 of the Form CMS-855A will not apply unless the person has hired an entity to exercise managerial control over the business (i.e., no owners will be listed in section 5, as the sole owner has already reported his/her personal information in sections 2 and 3).
- No owners, partners, or directors/officers need to be reported in section 6. However, all managing employees (whether W-2 or not) must be listed.
- The sole proprietor may list multiple authorized or delegated officials in sections 15 and 16.

Since most sole proprietorships that complete the Form CMS-855A will also have an employer identification number (EIN), the contractor shall request from the provider a copy of its CP-575, any federal tax department tickets, or any other preprinted information from the IRS containing the provider's EIN.

15.7.7.6 - Additional Form CMS-855A Processing Instructions (Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Non-Enrollment Functions

In some instances, the contractor cannot forward an application to the State until it performs certain non-enrollment functions pertaining to the application (e.g., the reimbursement unit needs to examine patient listing data). The contractor may flip the provider's status in the Provider Enrollment, Chain and Ownership System (PECOS) to "approval recommended" prior to the conclusion of the non-enrollment activity if: (1) all required enrollment actions have been completed, and (2) the non-enrollment action is the only remaining activity to be performed.

B. Multiple Providers under a Single Tax Identification Number (TIN)

Multiple providers may have the same TIN. However, each provider must submit a separate Form CMS-855A application and the contractor must create a separate enrollment record for each.

C. Future Effective Dates

If the contractor cannot enter an effective date into PECOS because the provider, practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the actual effective date is established (e.g., the tie-in notice is received), the contractor shall change the effective date in PECOS.

15.7.7.7 – Contractor Jurisdictional Issues

(Rev. 492, Issued: 12-06-13, Effective: 01-07-14, Implementation: 01-07-14)

A. Audit and Claims Contractors

1. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 15.8.1 of this chapter.

2. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

- (a) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS). Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. Any supporting documentation that contains personal health information or personally identifiable information may still be faxed to the claims contractor.
- (b) As applicable, fax or mail a copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

3. Tie-In/Tie-Out Notices and Approval Notices

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all tie-in/tie-out notices and approval letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of tie-in/tie-out notices and approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

B. Provider Nomination

With respect to provider nomination and changes of contractors, the contractor shall follow the instructions in Pub. 100-04, chapter 1, sections 20 through 20.5.1.

If the contractor receives a request from a provider to change its existing contractor, it shall refer the provider to the RO contact person responsible for contractor assignments.

15.7.8 – Special Processing Guidelines for Independent CLIA Labs, Ambulatory Surgical Centers and Portable X-ray Suppliers (Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless otherwise stated, all references to the "RO" in sections 15.7.8.2 through 15.7.8.5 of this chapter refer to the RO's survey & certification staff.

15.7.8.3.1 – Examining Whether a CHOW May Have Occurred (Rev. 474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Review of Sales Agreement

If the "Change of Ownership" box in section 1B of the Form CMS-855B is checked, the contractor shall ensure that the entire application is completed and that the supplier submits a copy of the sales agreement. The contractor shall review the sales agreement to determine whether:

1. The ownership change qualifies as a CHOW under the principles of 42 CFR §489.18 and Pub. 100-07, chapter 3, section 3210.1D;
2. Its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner;

3. The information contained in the agreement is consistent with that reported on the new owner's Form CMS-855B (e.g., same names)

If the sales agreement is unclear as to issues 1 and 2 above, the contractor shall request clarifying information from the supplier. (**NOTE:** Some sales agreements may fail to specifically refer to Medicare supplier agreements, assets, and/or liabilities, therefore requiring a close review of the sales agreement in its totality.) The information shall be in the form of additional legal documentation or a letter. If the clarification – for whatever reason - requires an update to the supplier's Form CMS-855B application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the Form CMS-855B (issue 3 above), the contractor shall seek clarifying information and, if necessary, obtain an updated Form CMS-855B.

In reviewing the application and the sales agreement, the contractor shall keep in mind the following:

- There may be instances where the parties in a CHOW did not sign a “sales agreement” in the conventional sense of the term; the parties, for example, may have documented their agreement in a “bill of sale.” The contractor may accept this alternative documentation in lieu of a sales agreement so long as the document furnishes clear verification of the terms of the transaction.

- While a CHOW is usually accompanied by a TIN change, this is not always the case; there may be a few instances where the TIN remains the same. Conversely, there may be cases where a supplier is changing its TIN but not its ownership. So while a change of TIN (or lack thereof) is evidence that a CHOW has or has not occurred, it is not the most important factor; rather, the change in the provider's ownership structure is.

- Form CMS-855B CHOW applications may be accepted by the contractor up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than 3 months in advance of the projected sale date shall be returned under section 15.8.1 of this chapter.

- On occasion, an ASC or PXRS may submit a Form CMS-855B change of information to report a large-scale stock transfer or other significant ownership change that the supplier does not believe qualifies as a CHOW. If the contractor has any reason to suspect that the transaction in question may indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the RO for guidance. Such referrals to the RO should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment has taken place and should not

be made as a matter of course. A RO CHOW determination is usually not required prior to the contractor making its recommendation.

B. Processing Steps

After performing the steps identified in subsection (A) above, the contractor shall abide by the following:

1. If the contractor believes that a CHOW has occurred but the new owner is not accepting the assets and liabilities of the old owner, the contractor shall treat the ASC/PXRS as a brand new supplier. It shall notify the ASC/PXRS that it must submit: (1) a Form CMS-855B voluntary termination to terminate the “old” facility, and (2) a Form CMS-855B initial enrollment for the “new” facility.
2. If the contractor believes that a CHOW has taken place and that the new owner is accepting the old owner’s assets and liabilities, it shall process the application normally and make a recommendation for approval to the State (with a cc: to the RO) or, if applicable, issue a denial. If the valid CHOW/acceptance of assignment was accompanied by a change in TIN, the transaction must be treated as a CHOW notwithstanding the general rule that a TIN change constitutes an initial enrollment. In other words, the reporting rules regarding CHOWs/assignments in this particular situation take precedence over the “change of TIN” principle.
3. If the contractor believes that a CHOW has not occurred and that the transaction merely represents an ownership change (e.g., minor stock transfer) that does not qualify as a 42 CFR §489.18-type CHOW, the transaction must be reported as a change of information. The only exception to this is if the change of information was accompanied by a change of TIN, in which case the supplier must enroll as a new entity.

NOTE: It is not uncommon for a supplier to undergo a financial or administrative change that it considers to be a CHOW but in actuality does not meet the regulatory definition identified in §489.18.

In scenario 2 above, the contractor shall not forward a copy of the CHOW application to the State agency until it has received and reviewed the final sales agreement. (In some cases, the supplier may submit an interim sales agreement with its application; this is acceptable, so long as it submits the final agreement in accordance with these instructions.) If the final sales agreement is not submitted within 90 days after the contractor’s receipt of the new owner’s application, the contractor shall reject the application. Though the contractor must wait until the 90th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what type of responses (short of the actual receipt of the sales agreement) were obtained.

C. Entry into the Provider Enrollment, Chain and Ownership System

(PECOS)

If it appears that the new owner will be accepting assignment as well as the assets and liabilities of the old owner, the contractor shall enter the changed data into the old owner's enrollment record in PECOS and, if applicable, switch the record to an "Approval Pending Regional Office Review" status. A new enrollment record shall not be created. If the RO approves the CHOW and sends the tie-in/approval notice to the contractor, the supplier's CMS Certification Number (CCN) will be maintained and the information in the existing record will be updated to reflect the new owner's information once the record is switched to an approved status.

If it appears that the new owner will not be accepting assignment as well as the assets and liabilities of the old owner, a new enrollment record shall be created containing the new owner's information.

D. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the supplier shall - per Pub. 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

15.7.8.3.2 – Electronic Funds Transfer (EFT) Payments and CHOWs

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

In a CHOW, the contractor shall continue to pay the old owner until it receives the tie-in/approval notice from the RO. Thus, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be rejected. It is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the contractor and RO are processing the CHOW. It is advisable that the contractor notify the supplier of this while the application is being processed.

If – pursuant to the CHOW – the seller submits a Form CMS-855B voluntary termination application, the contractor shall contact and explain to the seller that the ambulatory surgical center/portable x-ray supplier will not receive any payments until the RO approves the CHOW. (This is because payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process it; however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective.

15.7.8.4 - Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev.717, Issued: 05-12-17, Effective: 05-15-17, Implementation: 05-15-17)

(For purposes of this section 15.7.8.4, the terms “tie-in notices” and approval letters will be collectively referred to as tie-in notices. “Tie-out notices” are notices from the RO to the contractor that, in effect, state that the ASC’s/PXRS’s participation in Medicare should be terminated.)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice is generally issued in the following circumstances:

1. Initial enrollments
2. CHOWs
3. Voluntary terminations
4. Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the state/RO.

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855B Changes of Information, Stock Transfers, and Other Transactions

1. Referrals to State/RO

The following is a list of transactions that require a recommendation and referral to the state/RO:

- Addition of practice location
- Stock transfer
- Change in practice location or address in cases where a survey of the new site is required

In these situations, the Provider Enrollment, Chain and Ownership System

(PECOS) record should not be switched to “approved” until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

- (1) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,
- (2) The RO in question (based on the contractor’s past experience with this RO) does not treat stock transfers as potential CHOWs, and
- (3) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in (B)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to “approved).

2. Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the state/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or subunits
- Legal business name, tax identification number or “doing business as” name changes that do not constitute a CHOW
- Address changes that do not require a survey of the new location
- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials

- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

For these transactions, the contractor shall: (1) notify the supplier via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to “approved.” The contractor shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. The notice to the state/RO shall specify the type of information that is changing.

3. All Other Changes of Information

For all Form CMS-855B change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the supplier via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to “approved.” The state and RO need not be notified of the change.

4. Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) Form CMS-855B reactivation, (2) Form CMS-855B revalidation, or (3) full Form CMS-855B as part of a change of information (i.e., the supplier has no enrollment record in PECOS), the contractor shall make a recommendation to the state/RO and switch the record to “approval recommended” only if the application contains new/changed data falling within one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new practice location that was never reported to CMS via the Form CMS-855B, the contractor shall make a recommendation to the state/RO and await the RO’s approval before switching the record to “approved.” In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state/RO needs to consider is the new location.

If the application contains changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to “approved.” The contractor shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 days after it has completed processing the transaction.

C. Supplier-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice or approval letter for a transaction that concerns information not collected on the Form CMS-855B application, the contractor need not ask the supplier to submit a Form CMS-855B change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the supplier's Medicare participation because the supplier no longer meets the conditions of coverage, the contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the supplier's enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall **not** identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."

In addition, contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar. If CMS learns that the terminated provider plans to receive further surveys during the reasonable assurance period, then CMS will rescind the enrollment bar. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

E. Other Procedures Related to Tie-In/Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855B Not Completed

If the contractor receives a tie-in notice or approval letter from the RO but the supplier never completed the necessary Form CMS-855B, the contractor shall have the supplier complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency – There may be instances when the RO delegates the task of issuing tie-in notices, tie-out notices or approval letters to the state agency. The contractor may accept such notices from the state in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the state, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

3. Review for Consistency

When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855B. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

4. Creation of New Logging and Tracking (L & T) Record Unnecessary

The contractor is not required to create a new L & T record in PECOS when the tie-in notice or approval letter arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Supplier Inquiries

Once the contractor makes its recommendation for approval to the state/RO, any inquiry the contractor receives from the supplier regarding the status of its request for Medicare participation shall be referred to the state or RO.

6. Timeframes

So as not to keep the PECOS record in “approval recommended” status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

15.7.8.5 – Reserved for Future Use

(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)

15.7.8.6 - State Surveys and the Form CMS-855B

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Delay in State Survey

In general, information on the Form CMS-855B is still considered valid notwithstanding a delay in the State survey. However, the supplier must submit an updated Form CMS-855B application to the contractor if:

- The contractor becomes aware of such a delay;
- The delay is the fault of the supplier; and
- At least 6 months have passed since the contractor sent its recommendation for approval to the State.

If these criteria are met, the contractor shall send a letter to the supplier requesting an updated Form CMS-855B. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the supplier may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed Form CMS-855B certification statement.

If the supplier fails to furnish the requested information within 60 calendar days, the contractor shall submit a revised letter to the State that recommends denial of the supplier's application.

B. Future Effective Dates

If the contractor cannot enter an effective date into PECOS because the supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider and the effective date is established (e.g., the tie-in notice is received), the contractor shall change the effective date in PECOS.

15.7.9 – Indirect Payment Procedure

(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity under the indirect payment procedure (IPP). Sections 15.7.9.1 through 15.7.9.7 below outline the IPP registration process.

15.7.9.1 – Indirect Payment Procedure - Background

(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

Per 42 CFR § 424.66(a), Medicare may pay an entity for Part B services furnished by a physician or other supplier if said entity meets all of the following requirements:

- (1) Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).
- (2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.
- (3) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his/her behalf under 42 CFR § 424.36) to receive the Part B payment for the services for which the entity pays.
- (4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his/her survivors, or estate.
- (5) Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that comply with § 424.66(a) and the registration procedures described in sections 15.7.9.1 through 15.7.9.7 of this chapter are hereinafter referred to as “IPP entities.” An IPP entity is not a “provider” or “supplier” as those terms are defined in § 400.202; moreover, an IPP entity does not meet the definition of a “health care provider” under 45 CFR § 160.103 and, as such, is not eligible for a National Provider Identifier (NPI). Indeed, an IPP entity does not furnish Medicare services. Rather, it is an entity that provides supplementary coverage in the circumstances described in §424.66(a). To illustrate, suppose an IPP entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims. Assuming, again, that all requirements are met, entities that may utilize the IPP could include:

- Employers
- Unions
- Insurance companies
- Retirement homes
- Health care prepayment plans
- Health maintenance organizations
- Competitive medical plans
- Medicare Advantage plans

As stated, an IPP entity is not a Medicare provider or supplier. It therefore cannot enroll in the Medicare program. It is crucial, nonetheless, that Medicare obtain sufficient background information on prospective IPP entities to ensure the integrity, accuracy, and legitimacy of Medicare payments to said entities. Hence, CMS will apply the Form CMS-855 process to IPP entities consistent with our authority to request information under 42 CFR § 424.66(a)(5). For purposes of the IPP, this process is called IPP “registration,” rather than enrollment. An entity must satisfy the requirements described in 42 CFR § 424.66 and successfully complete the Form CMS-855 registration process before it can bill Medicare under the IPP. Naturally, an IPP entity’s status as a non-provider and non-supplier will result in procedures that differ in certain aspects from those associated with the enrollment of Medicare providers and suppliers.

15.7.9.2 - Submission of Registration Applications

(Rev. 590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Jurisdiction

An IPP entity’s registration application must be submitted to each Medicare claims administration contractor to which the IPP entity will be submitting claims. Claims

for all Part B items and services – other than for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – must be submitted to the A/B Medicare Administrative Contractor (MAC) or carrier based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides. However, claims for Medicare-covered implantable devices, although classified as DME, are submitted to the A/B MACs or carriers based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to submission of registration applications. As such, the IPP entity must complete and submit:

(1) Form CMS-855C and Form CMS-588 to each applicable A/B MAC to which the plan will be submitting its non-DMEPOS claims; and/or

(2) Form CMS-855C and Form CMS-588 to the National Supplier Clearinghouse (NSC).

With respect to (1) – and consistent with section 15.5.4.2(D) of this chapter - the IPP entity need only submit one Form CMS-855C application and one Form CMS-588 per contractor jurisdiction.

B. Form Completion

The IPP entity:

(1) Must use the paper version of the Form CMS-855 application.

(2) Must – in light of its ineligibility for an NPI - apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) in accordance with 45 CFR §162. This is to facilitate the entity's submission of claims under the IPP. The entity must furnish its HPID or OEID in the appropriate place on the Form CMS-855. It shall also list the HPID or OEID on the Form CMS-855 and Form CMS-588 and furnish documentation evidencing the issuance of the number (e.g., a notice from the HPID or OEID issuer identifying the number).

(3) Need not submit licensure or certification information.

(4) Shall list its main business address (e.g., its headquarters) and resident agent address (if applicable) as practice locations.

(5) Need not report medical record storage information.

(6) Need not pay an application fee (as it is not an “institutional provider” under 42 CFR §424.502), although it must receive payments via electronic funds transfer (EFT).

(7) Need not submit a Form CMS-460. Because §1842(h)(1) of the Social Security Act only permits “physicians and suppliers” to enter into participation agreements and because IPP entities do not meet the definition of a “supplier” at § 400.202, IPP entities

cannot enter into a participation agreement (Form CMS-460) with Medicare. The IPP entity shall therefore be treated as “non-participating.”

(8) Need not meet the applicable (a) supplier standards, (b) accreditation requirements, (c) surety bond requirements, and (d) liability insurance requirements if the IPP entity is a DMEPOS supplier. (The NSC may need to relax certain edits in the Provider Enrollment, Chain and Ownership System (PECOS).) Moreover, the contractor need not perform a site visit.

(9) Meet the attestation requirements in subsection (C) below.

C. Attestation

1. Contents

The IPP entity must submit with each registration application a signed attestation statement certifying that for each claim it submits, all of the following requirements in 42 CFR §424.66 are met:

(1) The entity provides coverage of the service under a complementary health benefit plan and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan.

(2) The entity has paid the person (i.e., the physician or other supplier) who provided the service (including the amount payable under the Medicare program) an amount that the physician or other supplier accepts as full payment.

(3) The entity has the written authorization of the beneficiary (or other person authorized to sign claims on the beneficiary’s behalf under 42 CFR §424.36) to receive the Part B payment for the services paid by the entity.

(4) The entity relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, the beneficiary’s survivors, or the beneficiary’s estate.

(5) The entity agrees to submit any information requested by CMS or by a Medicare contractor, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) The entity agrees to identify and exclude from its requests for payment all services for which Medicare is the secondary payer.

This attestation is necessary to help ensure that the entity is in compliance with the provisions of §424.66. As already stated, compliance with § 424.66 is a prerequisite for initial and continued registration as an IPP entity.

Since the IPP entity may be submitting applications in multiple jurisdictions, it is

acceptable for the entity to submit a photocopy of a signed attestation rather than an originally signed attestation.

2. Signature

An “authorized official” - as that term is defined in 42 CFR §424.502 – must sign all attestations, though the same authorized official need not sign all attestations.

The certification statement on the Form CMS-855C supplements - and does not supplant - the attestation referred to above. The IPP entity is bound by the terms of the certification statement to the same extent as it is bound by the attestation’s terms.

15.7.9.3 – Processing of Registration Applications (Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

A. Basic Requirements

Upon receipt of a Form CMS-855C registration application from an IPP entity, the contractor shall begin processing the application. This includes:

- Ensuring that the application is complete (see section D(1) below for additional information).
- Creating a logging & tracking (L & T) record and entering the IPP entity’s information in the Provider Enrollment, Chain and Ownership System (PECOS).
- Verifying the information on the application in accordance with (1) the “limited” category of screening (see section 15.19.2.1(A) of this chapter for more information), and (2) existing processing guidelines (e.g., reviewing all entities and individuals listed on the Form CMS-855 against the Medicare Exclusion Database and SAM).
- Ensuring that the attestation identified in section 15.7.9.2 above is submitted, signed by an authorized official, and contains the required language.
- As needed, asking the entity for additional or clarifying information using the procedures outlined in this chapter and other applicable CMS directives; this may include information – beyond the attestation itself – that is necessary to determine whether the entity is indeed in compliance with the provisions of 42 CFR §424.66.
- Assigning specialty code C2.
- Assigning a Provider Transaction Access Number (PTAN) (if the application is approved).

B. Prescreening

The contractor need not “prescreen” (as that term is described in section 15.7.1.1 of this chapter) the registration application.

C. Returns

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855C. If the contractor determines that one or more of these reasons applies, it shall return the registration application in accordance with the instructions outlined in that section.

D. Development Issues

If, in response to a development request, the IPP entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance.

E. Timeliness and Accuracy Standards

The timeliness and accuracy standards in sections 15.6.1.1.3, 15.6.1.2, 15.6.2.1, and 15.6.2.2 of this chapter apply to the processing of IPP initial applications and changes of information. Should the contractor exceed timeliness standards due to the requirements of sections 15.7.9.1 through 15.7.9.7, the contractor shall note the provider file in accordance with section 15.7.3 of this chapter.

F. HPID/OEID

The algorithm for the HPID/OEID is similar to that of the National Provider Identifier in that it will be 10 digits in length and will begin with either a “7” (HPID) or a “6” (OEID). The HPID/OEID will replace the placeholder NPI for IPP entities only.

15.7.9.4 – Disposition of Registration Applications

(Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

A. Approval

If the contractor determines that the IPP entity meets all necessary requirements, it shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) that contains: (1) the entity’s legal business name, “doing business as” name (if applicable) and HPID or OEID; (2) a draft approval letter patterned after the applicable model letter in section 15.7.9.7; and (3) any issues the contractor encountered in its review. The PEOG BFL will review the

matter and advise the contractor as to how to proceed.

If PEOG authorizes the approval, the contractor shall (1) switch the Provider Enrollment, Chain and Ownership System (PECOS) record to “Approved,” (2) establish an effective date that is the date on which the contractor approved the application, (3) assign a Provider Transaction Access Number (PTAN) or National Supplier Clearinghouse number (as applicable), and (4) send the approval letter via regular mail or e-mail to the entity no later than 3 business days after the contractor received authorization of the approval from PEOG.

After the entity is registered, the contractor (consistent with § 424.66(a)(5)) should request additional information in order to confirm the entity’s continued compliance with 42 CFR §424.66.

B. Denial

If the contractor determines that the entity does not meet all necessary requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity’s legal business name, “doing business as” name (if applicable), and HPID or OEID; (2) a draft denial letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor’s rationale for proposing to deny the application. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for denial include, but are not limited to, the following:

- (1) The entity does not comply with all applicable registration requirements.
- (2) The entity does not satisfy all of the requirements described in 42 CFR §424.66. (The contractor can contact its PEOG BFL for assistance on this issue.)
- (3) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and the SAM.

If the contractor believes that any other ground for denial exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the denial, the contractor shall (1) switch the PECOS record to “Denied,” and (2) send the denial letter via certified mail to the entity no later than 3 business days after the contractor received authorization of the denial from PEOG.

As indicated in the model denial letter in section 15.7.9.7, an entity should appeal the denial of its IPP registration application. Although IPP entities are neither

providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

C. Rejection

The Form CMS-855 shall be rejected if (1) the entity fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so (of the date of the request, as noted in section 15.8.2 and the examples found in section 15.7.1.5), or (2) the entity fails to timely submit new or corrected information in the scenarios described in section 15.8.2 of this chapter. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR §424.525(a). The rejection letter shall follow the format of the applicable letter in section 15.7.9.7 and shall be sent via regular mail no later than 5 business days after the contractor determines that the application should be rejected.

Prior PEOG approval of the rejection is unnecessary. However, as stated earlier, if the entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its PEOG BFL for guidance.

15.7.9.5 – Revocation of Registration

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

If the contractor determines that the entity no longer meets all necessary requirements, it shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft revocation letter patterned after the applicable model letter in section 15.7.9.7 below; and (3) the contractor's rationale for proposing to revoke the entity's registration. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for revocation include, but are not limited to, the following:

- (1) The entity no longer complies with all applicable registration requirements.
- (2) The entity no longer appears to be in compliance with the provisions of 42 CFR §424.66. (The contractor can contact its PEOG BFL for assistance regarding grounds (1) and (2).)
- (3) The entity has not complied with the terms of its signed Form CMS-855 certification statement (e.g., has not timely submitted an update to its registration information).
- (4) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual

with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and/or the SAM..

If the contractor believes that any other ground for revocation exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the revocation, the contractor shall (1) switch the PECOS record to “Revoked,” and (2) send the revocation letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the revocation from PEOG.

As indicated in the model revocation letter in section 15.7.9.7 below, an entity may appeal the revocation of its IPP registration. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

15.7.9.6 – Changes of Information and Other Registration Transactions

(Rev. 590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)

A. Changes of Information

An IPP entity is required to submit changes to its Form CMS-855C information in accordance with the terms of its signed Form CMS-855C certification statement. The contractor shall process such changes in accordance with existing instructions.

B. Other Transactions

1. Deactivations – The contractor shall not deactivate an entity’s IPP registration for any reason unless CMS instructs the contractor to do so.
2. Voluntary Terminations – If an IPP entity submits a voluntary termination application, the contractor shall process it in accordance with existing instructions.

15.7.9.7 – Registration Letters

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor shall use the following letters when approving, denying, or rejecting an application, or when revoking an entity’s registration.

A. Approval

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]

[Address]

[City, State & zip code]

Dear [Entity name]:

We are pleased to inform you that your Medicare Form CMS-855C registration application as an Indirect Payment Procedure (IPP) entity has been approved. Listed below is the information reflected in your Medicare Form CMS-855C record, including your Provider Transaction Access Number (PTAN).

For more information on how to bill Medicare, please contact our XXXXXXXX department at [insert phone number].

Your PTAN is also activated for use and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other related transactions. Please keep your PTAN secure.

Medicare Information

| | |
|-------------------|------------------|
| Entity name: | [Insert name] |
| Business address: | [Insert address] |
| PTAN: | [Insert PTAN] |
| Status: | IPP Entity |

Please verify the accuracy of this information. If you disagree with this initial determination or have any questions regarding the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation].

Consistent with 42 CFR §424.516, you must submit updates and changes to your Form CMS-855C information in accordance with specified timeframes. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) business address, and (3) payment information (such as changes in electronic funds transfer information). To download the CMS-855 applications, go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert Web site address] or the Centers for Medicare & Medicaid Services' (CMS) Web site at <http://www.cms.hhs.gov/home/medicare.asp>.

Sincerely,

[Your Name]

[Title]

B. Denial

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]

[Address]

[City, State & zip code]

RE: [insert decision]

Dear [Entity name]:

We have received and reviewed your Form CMS-855C registration application as an Indirect Payment Procedure (IPP) entity. Your application is denied. We have determined that you do not meet the conditions necessary to bill Medicare as an IPP entity.

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to bill Medicare as an IPP entity, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with the necessary registration requirements and must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Mail Stop AR-18-50
7500 Security Boulevard
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Mail Stop AR-18-50
7500 Security Boulevard
Baltimore, MD 21244-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

C. Rejection

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & ZIP Code]

Dear [Entity name]:

We received your Medicare Form CMS-855C registration application on [insert date]. We are rejecting your application and returning it to you for the following reason(s):

FACTS: [Insert ALL rejection reason(s) and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

Consistent with 42 CFR §424.525, prospective Indirect Payment Procedure (IPP) entities are required to submit a complete registration application and all necessary supporting documentation within 30 calendar days from the date of the contractor's request for missing/incomplete/clarifying information. If you would like to resubmit your registration application, please make sure to address the issues stated above and to sign and date the new certification statement page on your resubmitted application.

To submit a new registration application, you may download and complete the application from the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

You should return the complete application to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]

[Title]

D. Revocation

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]

[Address]

[City, State & ZIP Code]

[RE:]

Dear [Entity name]:

This is to inform you that your Medicare registration as an Indirect Payment Procedure (IPP) entity is being revoked effective [insert effective date of revocation].

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and re-establish your eligibility to be registered as an IPP entity, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with all registration requirements. The CAP request must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. . Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the revocation involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
7500 Security Blvd.
Mailstop: AR-18-50

Baltimore, MD 21244-1850

Consistent with 42 CFR §424.535(c), [insert contractor name] is establishing a re-registration bar for a period of [insert amount of time]. This bar only applies to your registration in the Medicare program. In order to re-register, you must meet all registration requirements.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

15.8 – Application Returns, Rejections and Denials

(Rev. 415, Issued: 04-13-12, Effective: 05-14-12, Implementation: 05-14-12)

15.8.1 – Returns

(Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

A. Reasons for Return

Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the National Supplier Clearinghouse) should immediately return the enrollment application to the provider or supplier only in the instances described below. This policy – again, unless stated otherwise in this chapter or in another CMS directive - applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations):

- The applicant sent its paper Form CMS-855 or Form CMS-20134 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).
- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSS), or MDPP supplier application submissions received between January 1, 2018 and March 31, 2018).
- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRSS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)
- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.
- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.
- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.
- The application is not needed for the transaction in question. Two common examples include:
 - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.
 - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.
- The provider or supplier submitted a revalidation application more than seven months prior to their revalidation due date.
- The MDPP supplier submitted an application with a coach start date more than 30 days in the future.
- A provider or supplier requests that their application be withdrawn prior or during processing.
- A provider or supplier submits an application that is an exact duplicate of an application that has been processed previously or one that is currently pending processing.
- A provider or supplier submits a paper Form CMS-855 or CMS-20134 application that is outdated (i.e.: a provider submits a Form CMS-855I application that was approved for use in 07/11, which was replaced with the 12/18 version, the 07/11 version shall be returned).

The contractor need not request additional information in any of these scenarios.

For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a “rejected” application and a “returned” application is that the former is typically based on the provider’s failure to respond to the contractor’s request for missing or clarifying information. A “returned” application is effectively considered a non-application.

B. Procedures for Returning the Application

If the contractor returns the application:

- It shall notify the provider via letter (sent by mail or e-mail) that the application is being returned, the reason(s) for the return, and how to reapply.
- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

If the contractor returns an application, it shall (1) keep the original application and supporting documents and return a copy, (2) make a copy or scan of the application and documents and return the originals to the provider, or (3) simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why. If the contractor chooses the third approach and the provider requests a copy of its application, the contractor should fax or mail it to the provider.

C. Other Impacts of a Return

1. Changes of Information and Changes of Ownership (CHOWs)

- a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider’s Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

- b. Timeframe Not Yet Expired - If the contractor returns a change of information

or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Return, Rejection, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 15.8.2 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider’s Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor returns a reactivation application, the provider’s Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor returns a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider’s Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider’s billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) returns it again, (2) rejects it per section 15.8.2 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider’s billing privileges, assuming the applicable time period has expired.

15.8.2 –Rejections

(Rev. 896; Issued: 08-30-19; Effective: 10-01-19; Implementation: 10-01-19)

A. Background

In accordance with 42 CFR § 424.525(a)(1) and (2), the contractor (including the National Supplier Clearinghouse) should reject the provider’s application if the provider fails to furnish complete information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation.

For purposes of this policy, this includes situations in which the provider submitted an application that falls into one of the following categories and, upon the contractor’s request to submit a new or corrected complete application, the provider failed to do so within 30 days of the request:

1. The Form CMS-855, Form CMS-20134, Form CMS-588 or Internet-based PECOS certification statement: (a) is unsigned; (b) is undated; (c) contains a

- copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); (e) for paper Form CMS-855I and Form CMS-855O or Form CMS-855R submissions where the authorized or delegated official or an physician/non-physician practitioner must sign the form, someone other than the required officials, or a physician or non-physician practitioner signed the form; or (f) certification statement is missing (paper CMS-855 submissions only).
2. The applicant failed to submit all of the forms needed to process a reassignment package within 30 calendar days of receipt.
 3. The Form CMS-855, Form CMS-20134 or Form CMS-588 was completed in pencil.
 4. The wrong application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment).
 5. The provider sent in its Internet-based PECOS certification statement via fax or email when it was not otherwise permitted to do so. (Refer to section 15.5.14.4 for scenarios when this is permitted).
 6. The provider failed to submit an application fee (if applicable to the situation).

The applications described in (1) through (6) above shall be developed, rather than returned. For instance, if the provider submits an application completed in pencil, the contractor shall request the provider to submit a new application, either in ink or via Internet-based PECOS.

B. Timeframe

The 30-day clock identified in 42 CFR § 424.525(a) starts on the date that the contractor mails, faxes, or emails the development letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the initial development letter was sent (as noted in the examples in section 15.7.1.5). However, the contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.

C. Incomplete Responses

The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested data, the contractor is not required to contact the provider again to request the remaining data. It can simply reject the application at the expiration of the aforementioned 30-day period. Consider the following examples:

- The provider submits a Form CMS-855A in which section 3 is blank. On March 1, the contractor requests that section 3 be fully completed. On March 14,

the provider submits a completed section 3A. However, section 3B remains blank. The contractor need not make a second request for section 3B to be completed. It can reject the application on March 31, or 30 days after its initial request was made.

- The provider submits an outdated version of the Form CMS-855B. On July 1, the contractor returns the application and requests that the provider resubmit its application using the current version of the Form CMS-855B. On July 15, the provider submits the correct version, but section 4B is blank. The contractor is not required to make a follow-up request regarding section 4B. It can reject the application on July 31.

D. Creation of Logging & Tracking (L & T) Record

If the contractor cannot create an L & T record in PECOS because of missing data and the application is subsequently rejected, the contractor shall document the provider file accordingly. If the contractor is able to create an L & T record for a rejected application, it shall flip the status to “rejected” in PECOS.

E. Other Impacts of a Rejection

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor rejects a change of information or CHOW submission per this section 15.8.2 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an email to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) notifying him or her of the rejection. PEOG will determine whether the provider’s Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor rejects a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the email referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Rejection, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either rejects it again, returns it per section 15.8.1 of this chapter, or denies it, the contractor shall send the email referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider’s Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor rejects a reactivation application, the

provider's Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor rejects a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) rejects it again, (2) returns it per section 15.8.1 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise –deactivate the provider's billing privileges, assuming the applicable time period has expired.

E. Additional Rejection Policies

1. Resubmission after Rejection – If the provider's application is rejected, the provider must complete and submit a new Form CMS-855 or Form CMS-20134 (either via paper or Internet-based PECOS) and all necessary documentation.

2. Applicability – Unless stated otherwise in this chapter or in another CMS directive, this section 15.8.2 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations).

3. Physicians and Non-Physician Practitioners – Prior CMS guidance instructed contractors to deny, rather than reject, incomplete applications submitted by physicians and certain non-physician practitioners. This policy no longer applies. Such applications shall be rejected if the physician or practitioner fails to provide the requested information within the designated timeframe.

4. Notice – If the contractor rejects an application, it shall notify the provider via letter (sent via mail or email) that the application is being rejected, the reason(s) for the rejection, and how to reapply. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be rejected.

5. Copy of Application – If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor should fax or mail it to the provider.

15.8.3 – Reserved for Future Use

(Rev. 356, Issued: 09-24-10, Effective: 10-26-10, Implementation: 10-26-10)

15.8.4 – Denials

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Denial Reasons

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) into its denial letter. The contractor shall not use provisions from this chapter 15 as the basis for denial. Except as described in section 15.8.4(B) below or as otherwise stated in this chapter, the contractor may issue a denial letter without prior approval from CMS' Provider Enrollment & Oversight Group (PEOG) of the denial or the denial letter. For MDPP suppliers, contractors shall always receive prior approval from PEOG by emailing EnrollmentEscalations@cms.hhs.gov.

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/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)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) 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. (See section 15.4.8 of this chapter for examples of suppliers that are not eligible to participate.)
- 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.

i. The provider or supplier does not meet standards specific to their supplier type (e.g., MDPPI Supplier standards outlined in 42 CFR §424.205(d)).

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: 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)) – Excluded/Debarred from Federal Program

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)) – Felony Conviction

The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR §1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries.

Offenses include, but are not limited in scope and severity to:

- 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, a re-enrollment bar will be established for providers and suppliers whose billing privileges are revoked, this does not preclude 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.

Note that if an MDPP coach is identified as having any of the above felony requirements, this would not constitute a denial under this category for the MDPP supplier, as the coach, not the supplier has the felony charge. The MDPP supplier would, however, have an enrollment denial under non-compliance for having an ineligible coach.

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 PEOG via the MACRevocationRequests@cms.hhs.gov mailbox for guidance.

Denial Reason 4 (42 CFR §424.530(a)(4)) – False or Misleading Information on Application

The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program.

Denial Reason 5 (42 CFR §424.530(a)(5)) – On-Site Review/Other Reliable Evidence that Requirements Not Met

Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

- (i) Is not operational to furnish Medicare-covered items or services; or

(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

Denial Reason 6 (42 CFR §424.530(a)(6)) – Existing Overpayment at Time of Application

(i) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof has an existing Medicare debt.

(ii) The enrolling provider, supplier, or owner (as defined in §424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:

(A) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination or revocation.

(B) The Medicare debt has not been fully repaid.

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse.

In making this determination under §424.530(a)(6)(ii), CMS considers the following factors:

(1) The amount of the Medicare debt.

(2) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.

(3) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.

(4) Whether the Medicare debt is currently being appealed.

(5) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.

A denial of Medicare enrollment under paragraph (a)(6) can be avoided if the enrolling provider, supplier or owner thereof does either of the following:

(A) Satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or

(B) Repays the debt in full.

Denial Reason 7 (42 CFR §424.530(a)(7)) – Medicare Payment Suspension

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)) – Home Health Agency (HHA) Capitalization

An 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)) – Hardship Exception Denial and Fee Not Paid

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)) – Temporary Moratorium

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.)

Denial Reason 11 (42 CFR §424.530(a)(11)) – DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) A physician or eligible professional's Drug Enforcement Administration (DEA)

Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or

(ii) The applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

B. Denial Letters

1. Prior PEOG Approval Necessary

For cases involving §424.530(a)(4) (Denial Reason 4 above) or MDPP Suppliers, the contractor shall obtain approval of both the denial and the denial letter from PEOG via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the denial letter. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior PEOG Approval Unnecessary

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. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be denied.

No reenrollment bar is 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. Other Impacts of a Denial

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor denies a change of information or CHOW submission per this section 15.8.4 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to the MACRevocationRequests@cms.hhs.gov mailbox notifying PEOG of the denial. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Denial, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it per section 15.8.1 of this chapter, or rejects it per section 15.8.2 of this chapter, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor denies a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor denies a revalidation application per this section 15.8.4, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall revoke the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) denies it again, (2) returns it per

section 15.8.1 of this chapter, or (3) rejects it per section 15.8.2 of this chapter, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – revoke the provider’s billing privileges, assuming the applicable time period has expired.

F. Provider Enrollment Appeals Process

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

15.9 – Application Approvals

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

15.9.1 - Non-Certified Suppliers and Individual Practitioners

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

(This section does not apply to ambulatory surgical centers, portable x-ray suppliers, or providers and suppliers that complete the Form CMS-855A.)

If the contractor approves a supplier’s enrollment, it shall notify the applicant via letter of the approval. The letter shall:

- Follow the content and format of the model letter in section 15.24.7 of this chapter;
- Include the National Provider Identifier (NPI) with which the supplier will bill Medicare and the Provider Transaction Access Number (PTAN) that has been assigned to the supplier as an identifier for inquiries.
- Provide instructions on how suppliers should use the assigned PTAN when they use the contractor interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility, check status or other supplier-related IVR transactions.
- Include language reminding suppliers to update their NPPES record whenever their information changes.

Absent a CMS instruction or directive to the contrary, the contractor shall send the approval letter within 5 business days of approving the enrollment application in PECOS. For all applications other than the Form CMS-855S, the letter shall be sent to the supplier’s contact person if one is listed; otherwise, the contractor may send the letter to the supplier at the supplier’s correspondence address or special payment address.

For claims submitted by physicians and non-physicians prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1,

section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant is appropriately licensed.

15.9.2 - Certified Providers and Certified Suppliers **(Rev. 561, Issued: 12-12-14, Effective: 03-18-15, Implementation: 03-18-15)**

(This section only applies to: (1) initial Form CMS-855A applications or change of ownership (CHOW), acquisition/merger, or consolidation applications submitted by the new owner; and (2) initial ambulatory surgical center and portable x-ray supplier applications.)

If the contractor decides to recommend approval of the provider or supplier's application, the contractor shall send a recommendation letter to the applicable State agency, with a copy to the Regional Office's (RO) survey and certification unit. (For those provider/supplier types that do not require a State survey, such as federally qualified health centers, the letter can be sent directly to the RO.) The recommendation letter shall, at a minimum, contain the following information:

- Supplier/Provider NPI Number
- CMS Certification Number (if available)
- Type of enrollment transaction (CHOW, initial enrollment, branch addition, etc.)
- Contractor number
- Contractor contact name
- Contractor contact phone number
- Date application recommended for approval (and, for FQHCs, the date that the package is complete)
- An explanation of any special circumstances, findings, or other information that either the State or the RO should know about.
- Any other information that, under this chapter 15, must be included in the recommendation letter.

The letter can be sent to the State/RO via mail, fax, or e-mail.

The contractor shall also:

- Send either a photocopy (not the original), faxed version, or e-mail version of the final completed Form CMS-855 to the State agency or RO (as applicable),

along with all updated Form CMS-855 pages, explanatory data, documentation, correspondence, final sales agreements, etc. (which can also be sent via mail, fax, or e-mail). If the CMS-855, associated documentation, and recommendation letter are mailed, they should be included in the same package.

The contractor shall not send a copy of the Form CMS-855 to the RO unless the latter specifically requests it or if the transaction in question is one for which State involvement is unnecessary.

- Notify the applicant that the contractor has completed its initial review of the application. The notification can be furnished via e-mail, or via the letter identified in section 15.24.6 of this chapter (which may be sent to the applicant's contact person), and shall advise the applicant of the next steps in the enrollment process (e.g., site visit, survey). The contractor may, but is not required to, send a copy of its recommendation letter to the provider as a means of satisfying this requirement. However, the contractor should not send a copy to the provider if the recommendation letter contains sensitive information.
- Inform initial applicants (including new owners that have rejected assignment of the provider's or supplier's provider agreement) that Medicare billing privileges will not begin before the date the survey and certification process has been completed and all Federal requirements have been met.
- Notify the applicant of the phone numbers and e-mail addresses of the applicable State agency and RO that will be handling the survey and certification process; the applicant shall also be instructed that all questions related to this process shall be directed to the State agency and/or RO.

15.9.3 - Approval of Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

As stated in 42 CFR §424.57(b), a DMEPOS supplier must, among other things, meet the following conditions to be eligible to receive payment for a Medicare-covered item:

- The supplier has submitted a complete Form CMS-855S, including all supporting documentation, to the National Supplier Clearinghouse (NSC); and
- The item was furnished on or after the date the NSC issued to the supplier a DMEPOS supplier number conveying Medicare billing privileges.

The date identified in the previous bullet represents the "date of approval."

15.9.4 - Approval of Medicare Diabetes Prevention Program

(MDPP) Suppliers

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

As stated in 42 CFR §424.205(d), an MDPP supplier must, among other things, not have an ineligible coach on its roster. Though the MDPP supplier's effective date for billing privileges is the date a successful Form CMS-20134 application was submitted, the contractor must notify MDPP suppliers of their application approval, as some MDPP suppliers may not begin furnishing services until receiving such information.

If the contractor approves a supplier's enrollment, it shall notify the applicant via letter of the approval. The letter shall:

- Follow the content and format of the model letter in section 15.24.7.1 of this chapter;
- Include the National Provider Identifier (NPI) with which the supplier will bill Medicare and the Provider Transaction Access Number (PTAN) that has been assigned to the supplier as an identifier for inquiries.
- Provide instructions on how suppliers should use the assigned PTAN when they use the contractor interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility, check status or other supplier-related IVR transactions.
- Include language reminding suppliers to update their NPPES record whenever their information changes.

Absent a CMS instruction or directive to the contrary, the contractor shall send the approval letter within 5 business days of approving the enrollment application in PECOS. The letter shall be sent to the supplier's contact person if one is listed; otherwise, the contractor may send the letter to the supplier at the supplier's correspondence address or special payment address.

For claims submitted by MDPP suppliers prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1, section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant submitted an application or CAP that resulted in being successfully enrolled.

15.10 – Changes of Information and Voluntary Terminations

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

Unless indicated otherwise, the instructions in sections 15.10.1 through 15.10.3 of this chapter apply to Part A and Part B enrollments.

15.10.1 – Changes of Information - General Procedures
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Unless otherwise specified in this chapter or another CMS directive, if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855 or Form CMS-20134. Letterhead is not permitted.

The provider shall (1) furnish the changed data in the applicable section(s) of the form, and (2) sign and date the certification statement. In accordance with 42 CFR §424.516(d) and (e), and 42 CFR §424.205(d), the timeframes for providers to report changes to their Form CMS-855 or Form CMS-20134 information are as follows:

A. 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.): The following changes must be reported within 30 days:

- A change of ownership
- A final adverse action
- A change in practice location

All other informational changes involving the providers listed in this section 15.10.1(A) must be reported within 90 days.

B. All providers and suppliers other than (1) those listed in section 15.10.1(A); (2) suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and (3) independent diagnostic testing facilities (IDTFs): Any change of ownership, including a change in an authorized or delegated official, must be reported within 30 days. All other informational changes involving the providers listed in this section 15.10.1(B) must be reported within 90 days.

The reporting requirements for IDTFs can be found in 42 CFR §410.33(g)(2) and in section 15.5.19.1(A)(2) of this chapter. Reporting requirements for DMEPOS suppliers can be found in 42 CFR §424.57(c)(2)). Reporting requirements for MDPP suppliers can be found in 42 CFR §424.205(g).

In addition:

- **Unsolicited Additional Information** - Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request. Rather, it is considered to be and shall be processed as a separate

change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.

- **Unavoidable Phone Number or Address Changes** – Unless CMS specifies otherwise, any change in the provider’s phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider’s street) must still be updated via the Form CMS-855 or Form CMS-20134.

- **Notifications** – For changes of information that do not require Regional Office approval (e.g., Form CMS-855I changes; Form CMS-855B changes not involving ambulatory surgical centers or portable x-ray suppliers; minor Form CMS-855A changes; Form CMS-20134 changes), the contractor shall (1) furnish written, email, or telephonic confirmation to the provider that the change has been made, and (2) document (per section 15.7.3 of this chapter) in the file the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP Code change, it is not necessary to send confirmation to the provider that the change has been processed.

15.10.1.1 – Changes of Information and Complete Form CMS-855 and Form CMS-20134 Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A provider must submit a complete Form CMS-855 or Form CMS-20134 application if it (1) submits any change request, and (2) does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS). (For purposes of this requirement, the term “change request” includes electronic funds transfer (EFT) changes.) It is immaterial (1) whether the provider or another party (e.g., local government changes street name) was responsible for triggering the changed data; or (2) the signer of the change request or EFT form already has a signature on file with the contractor.

If the contractor receives a change request from a provider that is not in PECOS, the contractor shall develop for the entire application in accordance with the procedures described in this chapter (i.e., the contractor shall treat the transaction as a request for additional information). Consistent with existing policies for requesting additional data, the provider has 30 calendar days from the date of the contractor’s request to furnish a complete Form CMS-855 or Form CMS-20134. During this period, the contractor should “hold” (i.e., not process) the change request until the entire application arrives; no logging and tracking (L & T) record shall be created in PECOS at this point.

If the provider fails to submit a complete application within the aforementioned 30-day period, the contractor shall follow the instructions in section 15.10.1.2(B) of this chapter.

If the provider submits the application, the contractor shall process it in accordance with the instructions in this chapter and all other applicable CMS directives. This includes:

- Processing the complete application consistent with the timeframes for initial applications in section 15.6.1 of this chapter.
- Ensuring that all data elements on the Form CMS-855 or Form CMS-20134 have been validated, as it would with an initial enrollment application. The contractor shall not approve the change request until all data on the complete Form CMS-855 has been validated.
- Creating an L & T record and enrollment record in PECOS prior to approving the change request. (The receipt date should be the date on which the complete application was received, not the date on which the initial change request was received.) The transaction should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the complete application will presumably incorporate the changed data reported on the original Form CMS-855 or Form CMS-20134 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

15.10.1.2 - Incomplete or Unverifiable Changes of Information (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall follow the instructions in this section 15.10.1.2 if a submitted change request cannot be processed to completion.

A. Provider Has an Established Enrollment Record in the Provider Enrollment, Chain and Ownership System (PECOS)

Assume that a provider with a PECOS enrollment record submits a Form CMS-855 or Form CMS-20134 change request and (1) fails to timely respond to the contractor's request for additional or clarifying information, or (2) the changed information cannot be validated. The contractor shall reject the change request in accordance with section 15.8.2 of this chapter. Moreover, if the changed information is of such materiality that the contractor cannot determine whether the provider still meets all enrollment requirements, the contractor shall refer the matter to its Provider Enrollment Integrity Group (PEOG) liaison for guidance. (For instance, if the data involves a change in the provider's lone practice location and the contractor cannot verify the validity of the new site, this clearly raises questions as to the provider's continued compliance with Medicare requirements.)

B. Provider is Not in PECOS

As stated in section 15.10.1.1 of this chapter, if a provider does not have an established enrollment record in PECOS and wants to change any of its existing

enrollment or electronic funds transfer (EFT) information, it must submit a complete Form CMS-855 or Form CMS-20134 before the contractor can effectuate the change. If the provider fails to submit the completed form within the applicable 30-day period, the contractor shall request that the provider revalidate its Medicare enrollment information per 42 CFR §424.515.

15.10.2 - Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers (Rev. 882; Issued: 05-24-19; Effective: 06-25-19; Implementation: 06-25-19)

A. Timeframe for Regional Office (RO) Approval

In situations where RO approval of the change of information is required, it is strongly recommended that the contractor advise the provider that it may take 6 months (or longer) for the request to be approved. The manner and timing in which this information is relayed lies solely within the contractor's discretion.

B. Post-Recommendation Changes

If an applicant submits a change request after the contractor makes a recommendation on the provider's initial CMS-855 application but before the RO issues a tie-in/approval notice, the contractor shall process the newly-submitted data as a separate change of information; it shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The contractor, however, need not enter the change request into the Provider Enrollment, Chain and Ownership System (PECOS) until the tie-in notice is issued.

In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.

C. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

D. Recommendation Before New HHA Location Established

If an HHA is adding a branch or changing the location of its main location or an existing branch, the contractor may make a recommendation for approval to the State/RO prior to the establishment of the new/changed location (notwithstanding any other instruction in this chapter to the contrary). If the contractor opts to make

such a recommendation prior to the establishment of the new/changed location, it shall note in its recommendation letter that the HHA location has not yet moved or been established.

E. Critical Access Hospital (CAH) Addition of a New Provider-Based Location

1. Regulations found at 42 CFR 485.610(e)(2) and in the State Operations Manual (SOM), Pub. 100-07, Chapter 2, Section 2256H state that the CAH's provider-based location must meet certain distance requirements from the main campus of another hospital or CAH.

The MAC shall reach out to the appropriate CMS Regional Office (RO) Division of Survey and Certification (DSC) during the processing of the CMS-855A for a verification that the CAH's new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main campus of another hospital or CAH. The MAC's recommendation of approval cannot be made without receiving a response from the RO DSC.

If the RO DSC finds that CAH's new provider-based location meets the distance requirements, the RO DSC will send a response to the MAC stating this. When this communication is received, the MAC shall continue processing as usual, up through issuing a recommendation of approval to the appropriate RO and/or State Agency (SA).

If the RO DSC responds that the new provider-based location does not meet the distance regulations, the MAC shall issue the rejection letter found below to CAH. The enrollment shall remain in an Approved status in PECOS.

The CAH will be provided three options by the RO DSC if it does not meet the distance requirements:

- a) The CAH keeps the new provider-based location, which will cause an involuntary termination in 90 days (as outlined in the State Operations Manual, Pub. 100-07, Chapter 3, Section 3012).
- b) The CAH will terminate the new provider-based location and continue their enrollment as a CAH.
- c) The CAH keeps the new provider-based location, but converts to a hospital (as outlined in the State Operations Manual, Pub. 100-07, Chapter 2, Sections 2256G and 2256H).

For each of these options, the MAC will keep the CAH's enrollment in an approved status in PECOS. In the case of option (a) above, the MAC will receive a tie-out notice for termination, which will lead to revocation of the CAH's enrollment. For option (b), the CAH's enrollment remains approved

and the MAC shall expect no further communication from the RO DSC. If the CAH chooses option (c) to convert to a hospital, the MAC will receive a CMS-855A to terminate the CAH's enrollment and a new CMS-855A to enroll as a hospital.

2. [month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) to add a new provider-based location to your Critical Access Hospital enrollment on [date]. We are rejecting your application because the CMS Regional Office, Division of Survey and Certification (RO DSC) has found that your new location does not meet distance requirements found in 42 CFR 485.610(e)(2).

Please refer to communications from the RO DSC for instructions for your next steps regarding the new provider-based location.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.10.3 – Voluntary Terminations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Voluntary terminations shall be processed in accordance with the timeframes in section 15.6.2, et al. of this chapter.

If the termination involves a certified provider or certified supplier, the contractor may terminate the entity without making a recommendation to the State and Regional Office (RO). Within 3 business days after the contractor finishes processing the termination, however, it shall notify the State and RO of this via

letter, e-mail, or fax.

Upon receipt of a voluntary termination, the contractor may ask the provider to complete the “Special Payments” portion of section 4 of the Form CMS-855 or Form CMS-20134 so that future payments can be sent thereto. If the provider has no special payments address already on file, the addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the provider wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The provider is not required to submit a Form CMS-588 in conjunction with a termination.

When processing a voluntary termination of a reassignment, the contractor shall contact the group to confirm that: (1) the group member PTAN is being terminated from all locations; and (2) if multiple group member PTANs exist for multiple group locations, each PTAN is terminated. However, if a group has one PTAN with multiple addresses, the contractor need not contact the group to confirm the termination.

15.11 – Electronic Fund Transfers (EFT)

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 or Form CMS-20134 before the contractor can effectuate the change.

With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data. Under 42 CFR §424.510(d)(2)(iv) and §424.510(e):

- All providers (including Federal, State and local governments) enrolling in Medicare must use EFT in order to receive payments. Moreover, any provider not currently on EFT that (1) submits any change to its existing enrollment data or (2) submits a revalidation application must also submit a Form CMS-588 and thereafter receive payments via EFT.
- If a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must continue to receive payments via EFT. However, the change in contractors does not require the provider to submit a new Form CMS-588 unless CMS states otherwise.

- For web-based application submissions, the Form CMS-588 shall be submitted via PECOS upload functionality.

B. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

- The information submitted on the Form CMS-588 is complete and accurate.
- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.
- The routing number and account number matches what was provided on the Form CMS-588.
- The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or via PECOS upload functionality).
- If the Form CMS-588 is received and is missing the checkbox for the Social Security Number (SSN) or Employer Identification Number (EIN), but the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the application, the contractor may proceed without development back to the provider or supplier.

Once the Form CMS-588 has been processed, the 588 form will be printed and delivered to the contractor's financial area along with the voided check and letter from the bank verifying account information, for proper processing of the EFT information. If this information cannot be verified and the provider fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855 or Form CMS-20134.

C. Miscellaneous Policies

1. Banking Institutions - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider's bank of choice does not or will not participate in the provider's proposed EFT arrangement, the provider must select another financial institution.

2. Verification - The contractor shall ensure that all EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.

3. Sent to the Wrong Unit - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 or Form CMS-20134 in the file.

4. Bankruptcies and Garnishments – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel.

5. Closure of Bank Account – If a provider has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider on payment withhold until an EFT agreement (and Form CMS-855 or Form CMS-20134, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence deactivation procedures in accordance with the instructions in this chapter. The basis for deactivation would be §424.540(a)(2) due to the provider's failure to comply with the EFT requirements outlined in §424.510(e)(1) and (e)(2).

6. Reassignments – If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

7. Final Payments – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider's EFT account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855, or Form CMS-20134, Form CMS-588 request identifying where it wants payments to be sent.

8. Chain Organizations - Per CMS Publication 100-04, chapter 1, section 30.2, a Part A chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100

providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted. If any of the chain providers have never completed a Form CMS-855A, they must do so at that time.

15.12 – Reserved for Future Use

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

15.13 – Existing or Delinquent Overpayments

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Consistent with 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502) of the applying provider or supplier, or (2) the applying physician or non-physician practitioner, has an existing overpayment that is equal to or exceeds a threshold of \$1,500 and it has not been repaid in full at the time the application was filed. To this end, the contractor shall:

- When processing a Form CMS-855A, CMS-855B, CMS-855S, or CMS-20134 initial or change of ownership application, determine – using a system generated daily listing - whether any of the owners listed in section 5 or 6 of the application has an existing or delinquent Medicare overpayment.
- When processing a Form CMS-855I initial application, determine – using a system generated daily listing - whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term “non-physician practitioner” 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.)

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior approval from CMS’ Provider Enrollment & Oversight Group (PEOG) is required before proceeding with the denial. The contractor shall under no circumstances deny an application under §424.530(a)(6) without receiving PEOG approval to do so.

Consider the following examples:

Example #1: Hospital X has a \$200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new Form CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a \$50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the \$50,000 overpayment was attached to him as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the \$50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a \$20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a Form CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the \$20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

NOTE: The contractors shall also observe the following:

- In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.
- The instructions in this section 15.8.4 apply only to (1) initial enrollments, and (2) new owners in a change of ownership.

The term "owner" under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)

- If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 15.8.4, the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

15.14 – Special Processing Situations

(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)

15.14.1 – Non-CMS-855 and non-CMS-20134 Enrollment Activities (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

There are situations where the contractor processes non-CMS-855 forms, Form CMS-20134, and other documentation relating to provider enrollment. Such activities include:

- EFT agreements (Form CMS-588) submitted alone
- "Do Not Forward" issues
- Par agreements (Form CMS-460)
- Returned remittance notices
- Informational letters received from other contractors
- Diabetes self-management notices
- Verification of new billing services
- Paramedic intercept contracts
- 1099 issues that need to be resolved

Unless specified otherwise in this chapter or another CMS directive, the contractor shall not create a logging and tracking record for any non-CMS-855 or non-CMS-20134 document or activity other than the processing of par agreements. The contractor should track and record all other activities internally.

15.14.2 – Contractor Communications (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the “owning contractor”) to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)

Occasionally, updates, changes, or corrections do not come to the owning contractor’s attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the “requesting” contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax of the need to update/change/correct information in a provider's PECOS record. The notification must contain:

1. The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier; and
2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or Form CMS-20134).

Within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) liaison for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or Form CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from "B."

15.14.3 – Provider-Based

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall adhere to the following regarding the enrollment of provider-based entities:

- **Certified Provider or Certified Supplier Initially Enrolling** – Suppose an HHA or other certified provider or certified supplier wishes to enroll and become provider-based to a hospital. The provider/supplier must enroll with the contractor as a separate entity. It cannot be listed as a practice location on the hospital's Form CMS-855A.
- **Certified Provider or Certified Supplier Changing its Provider-Based Status** – If a certified provider or certified supplier is changing its status from

provider-based to freestanding or vice versa, it need not submit any updates to its Form CMS-855 enrollment.

- **Group Practice Initially Enrolling** – If a group practice is enrolling in Medicare and will become provider-based to a hospital, the group generally must enroll via the Form CMS-855B if it wants to bill for practitioner services. The group would also need to be listed or added as a practice location on the hospital's Form CMS-855A.
- **Group Practice Changing from Provider-Based to Freestanding** – In this situation, the hospital should submit a Form CMS-855A change request that deletes the clinic as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.
- **Group Practice Changing from Freestanding to Provider-Based** – Here, the hospital must submit a Form CMS-855A change request adding the group as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.

Unless the CMS regional office (RO) dictates otherwise, the contractor shall not delay the processing of any practice location addition applications pending receipt of provider-based attestations or RO approval of provider-based status.

15.14.6 – Participation (Par) Agreements and the Acceptance of Assignment

(Rev. 592, 05-08-15, Effective: 06-08-15, Implementation: 06-08-15)

15.14.6.1 – General Information

(Rev. 592, 05-08-15, Effective: 06-08-15, Implementation: 06-08-15)

The contractor shall follow the instructions in CMS Publication 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

Individual physicians and non-physician practitioners who reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice, separate from the reassignment of benefits agreement, he/she may designate their own Par status. Refer to the instructions in Publication 100-04, chapter 1, section 30 for applying the correct Par status to clinic/group practices, organizations and individuals in private practice.

15.14.6.2 – PECOS Information

(Rev. 592, Issued: 05-08-15, Effective: 06-08-15, Implementation: 06-08-15)

All providers/suppliers must choose to be either Par or Non-Par when enrolling and must maintain the same Par status across all lines of business. The MAC shall search PECOS to determine if an enrollment already exists with the enrolling provider or supplier's legal business information (i.e.: Legal Business Name, Federal Tax Identification Number).

No Par status change shall be made by the MAC without confirmation from the provider/supplier first. In the event that a provider/supplier submits a Par Agreement and they are currently enrolled as Non-Par, the MAC must confirm with the provider/supplier that the change in the Par status is valid for all lines of business. Likewise, if a provider/supplier does not submit a Par Agreement, and they are enrolled as Par or Non-Par, the MAC shall confirm that the provider or supplier is not changing their current Par status across all lines of business.

15.14.7 – Opting-Out of Medicare

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Normally physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.

However, certain types of physicians and practitioners may “opt-out” of Medicare. A physician or practitioner who opts-out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services. Medicare does not pay anyone for services (except for certain emergency and urgent care services) furnished by an opt-out physician or practitioner. Instead, opt-out physicians and practitioners sign private contracts with beneficiaries. Please refer to Pub. 100-02, Chapter 15, sections 40 – 40.39 for more information regarding maintaining opt-out affidavits and the effects of improper billing of claims during an opt-out period. The instruction included in this chapter is intended for processing opt-out affidavits by the Provider Enrollment staff at the Medicare Administrative Contractors (MACs).

15.14.7.1 – Who May Opt-out of Medicare

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Only certain physicians and non-physician practitioners (referred to as “eligible practitioners” in this section), but not organizations, can “opt-out” of Medicare.

Physicians who are:

- Doctors of medicine or osteopathy,
- Doctors of dental surgery or dental medicine,
- Doctors of podiatry, or

- Doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed.

Non-Physician Practitioners who are

- Physician assistants,
- Nurse practitioners,
- Clinical nurse specialists,
- Certified registered nurse anesthetists,
- Certified nurse midwives,
- Clinical psychologists,
- Clinical social workers, or
- Registered dietitians or nutrition professionals who are legally authorized to practice by the State and otherwise meet Medicare requirements.

This means that neither the eligible practitioner nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the eligible practitioner and the beneficiary that states, in essence, that neither one can receive payment from Medicare for the services that were performed. (The contract, of course, must be signed before the services are provided so the beneficiary is fully aware of the physician's opt-out status.) Moreover, the eligible practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The provider enrollment unit must process these affidavits.

Eligible Practitioners that opt-out of Medicare are not the same as non-participating physicians/suppliers. Non-participating physicians/suppliers are enrolled in Medicare and choose on a claim-by-claim basis whether they want to accept assignment unless the service can only be paid on an assignment related basis as required by the law (e.g., for drugs, ambulance services, etc.). Therefore, non-participating physicians/suppliers must comply with Medicare's mandatory claim submission, assignment, and limiting charge rules. Conversely, opt-out physicians/practitioners are excused from the mandatory claim submission, assignment, and limiting charge rules but **only** when they maintain compliance with all of the requirements for opting out.

In an emergency care or urgent care situation, an eligible practitioner who has opted-out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the eligible practitioner must complete a CMS-855 application.

**15.14.7.2 – Requirements for an Opt-out Affidavit
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

As stated in Pub. 100-02, Chapter 15, Section 40.9, the affidavit shall state the following, that upon signing the affidavit, the eligible practitioner agrees to the following requirements:

1. Except for emergency or urgent care services, during the opt out period the eligible practitioner will provide services to Medicare beneficiaries only through private contracts, but for their provision under a private contract, would have been Medicare-covered services;
2. The eligible practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt out period, nor will the eligible practitioner permit any entity acting on the eligible practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary;
3. During the opt out period, the eligible practitioner understands that he/she may receive no direct or indirect Medicare payment for services that the eligible practitioner furnishes to Medicare beneficiaries with whom the eligible practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan;
4. An eligible practitioner who opts out of Medicare acknowledges that, during the opt out period, the eligible practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the eligible practitioner's services, directly or on a capitated basis;
5. On acknowledgment by the eligible practitioner to the effect that, during the opt out period, the eligible practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the eligible practitioner has entered into;
6. Acknowledge that the eligible practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the eligible practitioner during the opt out period (except for emergency or urgent care services furnished to the beneficiaries with whom the eligible practitioner has not previously privately contracted) without regard to any payment arrangements the eligible practitioner may make;
7. With respect to an eligible practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;

8. Acknowledge that the eligible practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services;
9. Identify the eligible practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the eligible practitioner during the opt-out period; and
10. Be filed with all MACs who have jurisdiction over claims the eligible practitioner would otherwise file with Medicare, and 42 CFR §405.420 the initial 2-year opt-out period will begin the date the affidavit meeting the requirements of is signed, provided the affidavit is filed within 10 days after the eligible practitioner signs his or her first private contract with a Medicare beneficiary.

MACs shall review initial opt-out affidavits to ensure that they contain the following information in order to create an affidavit record in PECOS:

The eligible practitioner's personal information:

- Full name (first, middle and last),
- Birthdate,
- Address and telephone number,
- License information and
- NPI (if one has been obtained), and
- SSN (if no NPI has been issued).

If MACs need to obtain any data that may be missing in an affidavit, in order to create a PECOS affidavit record, they may obtain that information from other sources (such as the state license board) or they should contact the eligible practitioner only **one time** directly. Contractors shall **not** use Internet-Based PECOS or the CMS 855 form to obtain the information from the eligible practitioner, as the eligible practitioner **is not** enrolling in Medicare. If the eligible practitioner is requested to submit missing information to allow for processing of the affidavit and fails to do so within 30 days, the MAC shall reject the opt-out affidavit.

15.14.7.2.1 – Opting-out and Ordering and Referring (Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

If an eligible practitioner that wishes to opt-out elects to order and refer items and services, the MACs shall develop for the following information (if not provided on the affidavit):

- An NPI (if one is not contained on the affidavit voluntarily);

- Date of Birth, and;
- SSN (if not contained on the Affidavit).

Note: MACs shall review the List of Excluded Individuals and Entities (LEIE) on the OIG's website and the Excluded Parties List on the GSA's System for Award Management (SAM) for all eligible practitioners that submit opt-out affidavits. Excluded eligible practitioners may opt-out of Medicare, but cannot order or refer.

If the information listed above is requested but not received, the eligible practitioner's affidavit can be processed, but the eligible practitioner cannot be listed as an ordering and referring provider.

15.14.7.2.2 – Acceptable Opt-out Affidavit Formats (Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

MACs may provide a sample opt-out affidavit form for eligible practitioners to complete. The opt-out affidavit form must provide spaces for the eligible practitioners to provide their personal information.

Eligible practitioners may also create their own affidavit. If the practitioner elects to do so, he/she should include information found in Section 15.14.7.2.2.1 to ensure timely processing of their opt-out affidavit.

15.14.7.2.2.1 – Opt Out Affidavit Sample Form (Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

MACs and eligible practitioners may use the information below as their opt-out affidavit form.

I, {Enter Physician/Non-Physician Practitioner Name}, being duly sworn, depose and say:

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt-out period.
- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.

- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under Medicare Advantage.
- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.
- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.
- I have identified myself sufficiently so that the MAC can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.
- I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two-year opt-out period will begin the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Eligible practitioners should also be encouraged to include the following information (to complete an affidavit record in PECOS):

- Eligible Practitioner's NPI
- Eligible Practitioner's Medicare Identification Number (if issued)
- Eligible Practitioner's Social Security Number
- Eligible Practitioner's Date of Birth
- Eligible Practitioner's Specialty
- Eligible Practitioner's E-mail Address
- Eligible Practitioner's request to Order & Refer

15.14.7.3 – Requirements of a Private Contract

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

In order to opt-out of Medicare, the eligible practitioner shall complete a “private contract” with their patients that are Medicare beneficiaries. Please refer to Pub. 100-02, Chapter 15, Section 40.8 for private contract definitions and requirements.

15.14.7.4 – Determining an Effective Date of an Opt-out Period

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

As noted in Pub. 100-02, Chapter 15, Section 40.17, eligible practitioners receive effective dates based on their participation status.

A. Eligible practitioners that have never enrolled with Medicare

Eligible practitioners are not required to enroll prior to opting-out of Medicare. If a non-enrolled eligible practitioner submits an opt-out affidavit, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

B. Previously Enrolled Non-Participating Practitioners

If a previously enrolled eligible practitioner that is a non-participating physicians/suppliers decides to terminate their active Medicare billing enrollment and instead opt-out of Medicare, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

C. Previously Enrolled Participating Physicians/Suppliers

If a previously enrolled eligible practitioner that is a participating provider (one that accepts assignment for all their Medicare claims) decides to terminate his/her active Medicare billing enrollment and opt-out of Medicare, the effective date of the opt-out period begins the first day of the next calendar quarter. An opt-out affidavit must be received at least 30 days before the first day of the calendar quarter in order to receive January 1, April 1, July 1 or October 1 as their effective date. If the opt-out affidavit is received within 30 days prior to January 1, April 1, July 1 or October 1, the effective date would be the first day of the next calendar quarter. (For example, an enrolled participating eligible practitioner’s opt-out affidavit was submitted on December 10th. The eligible practitioner’s effective date could not be January 1, as the affidavit was not received 30 days prior to January 1. The effective date would be April 1.) The eligible practitioner would need to remain enrolled as a participating physician/supplier until the end of the next calendar quarter so that claims can be properly submitted until the opt-out period begins.

15.14.7.5 – Emergency and Urgent Care Services

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

In the case that an eligible practitioner that has opted-out of Medicare provides emergency or urgent care services, that eligible practitioner must submit an application for enrollment via the Provider Enrollment Chain and Ownership System (PECOS) or a paper CMS-855I application. Once the eligible practitioner has received his/her Provider Transaction Access Number (PTAN), he/she must submit the claim(s) for any emergency or urgent care service provided. MACs shall contact their Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for additional guidance when this type of situation arises. Please refer to Pub. 100-02, Chapter 15, Section 40.28 for more information on Emergency and Urgent Care Services.

15.14.7.6 –Termination of an Opt Out Affidavit (Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

As noted in Pub. 100-02, Chapter 15, Section 40.35, an eligible practitioner who has not previously opted-out may terminate their opt-out period early, however notification must be given to the MAC, in writing, signed by the eligible practitioner no later than 90 days after the effective date of the initial 2-year opt-out period. In order to properly terminate an affidavit, the eligible practitioner must:

1. Not have previously opted-out of Medicare (the eligible practitioner cannot terminate a renewal of his/her opt-out);
2. Notify all the MACs that the eligible practitioner has filed an affidavit no later than 90 days after the effective date of the affidavit;
3. Notify all beneficiaries (or their legal representation), that the eligible practitioner entered into private contracts with, of the eligible practitioner's decision to terminate their opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period and;
4. Refund to each beneficiary all payments collected in excess of the Medicare limiting charge or deductibles and coinsurance.

For eligible practitioners that were previously enrolled to bill Medicare for services, the MAC shall reactivate the eligible practitioner's enrollment record in PECOS and reinstate his/her PTAN as if no opt-out affidavit existed. The physician or NPP may bill for services provided during the opt-out period.

For eligible practitioners that were not previously enrolled to bill Medicare for services, the MAC shall remove the affidavit record from PECOS so that the eligible practitioner can submit the appropriate application(s) (via PECOS or paper CMS-855 for individual and/or reassignment enrollment) in order to establish an enrollment record in PECOS, so the physician or NPP may bill for services rendered during the opt-out period.

15.14.7.7 – Opt-out Period Auto-Renewal and Cancellation of the Opt-out Affidavit

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Eligible practitioners that initially opted-out or renewed an affidavit on or after June 16, 2015 need not submit a renewal of their affidavit. The opt-out will be automatically renewed for another 2 year period. However, if the eligible practitioner decides to cancel his/her opt-out, he/she must submit a written, signed notice to each MAC to which he or she would file claims absent the opt-out, not later than 30 days before the end of the current 2-year opt-out period.

If the eligible practitioner decides to enroll in Medicare after his or her opt-out is canceled, he or she must submit an application via PECOS or a paper CMS-855I application. The effective date of enrollment cannot be before the cancellation date of the opt-out period. (For example, an eligible practitioner submits a cancellation of his or her opt-out to end the period on March 31, which is two years from the eligible practitioner's opt-out affidavit effective date. His/her requested Medicare effective date of enrollment cannot be before April 1.)

15.14.7.7.1 – Opt-out Period Auto-Renewal Report and Opt-Out Renewal Alert

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The MACs shall issue an Opt-Out Renewal Alert Letter (found in Section 15.24.16.6 of this chapter) to any eligible practitioners whose opt-out period is set to auto-renew.

To accomplish this, CMS will provide a monthly opt-out report to all contractors via the Share Point Ensemble site. The MACs shall access the report monthly through the Share Point Ensemble site. The MACs shall review the opt-out report for opted-out eligible practitioners that will auto-renew in the next 3 and a half months. MACs shall issue an Auto-Renewal Alert Letter to eligible practitioners at least 90 days prior to the auto-renewal date, so the eligible practitioner has at least 60 days prior to the date a cancellation notice must be submitted to cancel the current opt-out.

The Opt-out Auto-Renewal Alert Letter will provide the date the current opt-out period will be auto renewed and the date that the eligible practitioner will need to submit a cancellation request. The letter will provide the eligible practitioner appeal rights if he/she fails to submit a cancellation request and the opt-out renews.

The MACs shall complete the Opt-Out Renewal Alert Letter Report to include the date the Alert Letter was issued and post their reports no later than the 15th of the following month to the Share Point Ensemble site and email their PEOG BFL when the report has been posted.

If an eligible practitioner submits a CMS-855I and/or a CMS-855R (paper or web application) without submitting a cancellation request of his or her opt-out, the MACs shall issue a development for the cancellation notice. Once the cancellation notice is received, the MACs shall then process the application(s).

If the eligible practitioner submits a cancellation request (after development, as noted above, or without a prior application submission) at least 30 days before the end of the current opt-out period or after the opt-out period automatically renews, MACs shall contact their Provider Enrollment & Operations Group (PEOG) Business Function Lead (BFL) for guidance regarding the opt-out cancellation. This guidance will be issued on a case-by-case

15.14.7.8 – Opting-out vs. Enrolling for the Sole Purpose of Ordering and Referring and/or Prescribing (Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Physicians and certain non-physician practitioners (NPPs) who wish to enroll for the sole purpose of ordering and referring submit an application via PECOS or via the paper form CMS-855O application. These physicians and NPPs do not receive payments from Medicare, as they do not submit claims as performing providers.

An eligible practitioner that has opted out of Medicare does not need to additionally submit an application to enroll as an ordering and referring provider, if they indicate that they wish to order and refer (providing the necessary information on their affidavit as noted in Section 15.14.7.2).

15.14.7.9 – Failure to Properly Cancel or Terminate Opt-out (Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Eligible practitioners that fail to properly cancel or terminate their opt-out shall be provided an opportunity to appeal the decision to continue the auto-renewal of the opt-out or continuation of the eligible practitioner's initial opt-out period.

The Opt-Out Approval letters include appeal rights for eligible practitioners that initially opt-out and fail to properly terminate the opt-out within 90 days of the approval.

15.14.8 – Assignment of Part B Provider Transaction Access Numbers (PTANs) (Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assign additional PTAN(s) to a supplier merely because the individual or entity requests one - the only exception being for hospitals that request separate billing numbers for their

hospital departments in section 2C of the Form CMS-855B. However, a hospital requesting an additional PTAN must associate the new PTAN with a National Provider Identifier in section 4 of the Form CMS-855.

15.15 – Internet-based PECOS Applications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

This section furnishes guidance to contractors on the proper handling and processing of Form CMS-855 or Form CMS-20134 applications submitted via the Internet (hereinafter referred to as "Internet-based PECOS" applications). Unless otherwise stated:

- The instructions in this section 15.15 apply only to Internet-based PECOS applications.
- The instructions in sections 15.7 through 7.1.6.2 of this chapter take precedence over those in this section 15.15.

A. General Background Information

The principal logging and tracking (L & T) statuses for PECOS Internet applications that are not in a final status are:

- Received;
- In Review;
- Returned for Corrections;
- Corrections Received;
- Review Complete; and
- Application in Process.

The submission of a PECOS Internet application will immediately place the L & T record into a "Received" status.

B. Certification Statement

Refer to section 15.5.14 for the certification statement and signature requirements.

C. Application Returns

If the contractor can determine (without actively processing the application) that an application can be returned under section 15.8.1 of this chapter (e.g., was submitted more than 30 days prior to the effective date), the contractor shall return the application without waiting for the arrival of the certification statement.

D. Switch to "In Review" Status

After – and only after - it receives and accepts the provider’s certification statement, the contractor shall: (1) enter the date of signature into the “Certification Date” box in the L & T record, and (2) change the L & T status to “In Review.” The contractor, in other words, shall not initiate any application verification activities prior to its receipt and acceptance of the certification statement and its completion of tasks (1) and (2) in the previous sentence.

After changing the L & T status to “In Review,” the contractor shall review the Application Data Report (ADR), and shall commence all applicable validation activities identified in this chapter. (The ADR is only available for printing when the L & T record is in one of the following statuses: “In Review,” “Returned for Corrections,” or “Corrections Received.”)

E. Transferral of Data into PECOS

Once the contractor ties the L & T record to the enrollment record, the contractor shall begin the process of transferring the data into PECOS by accepting or rejecting the various data elements. The contractor shall note that: (1) it cannot undo any transfer of information into PECOS, and (2) once the L & T is tied to the enrollment record, the application cannot be returned to the provider for corrections.

F. Miscellaneous Instructions

NOTE: The contractor is advised of the following:

- **Deletion of Erroneous Record** - The contractor shall only delete an erroneously created L & T record by: (1) moving the L & T record to a status of “Rejected,” and (2) using an L & T status reason of “Deleted.”
- **Gatekeeper/Enrollment Screens** - The Gatekeeper and Enrollment screens are only used in the case of Form CMS-855 or Form CMS-20134 initial enrollment PECOS Internet submissions.
- **Post-Processing Recordkeeping** - After processing a particular PECOS Internet transaction, the contractor shall maintain in the provider’s file: (1) a copy of the final version of the ADR, (2) all submitted certification statements and applicable supporting documents, and (3) documentation of all contacts with the provider (e.g., phone calls, emails) per section 15.7.3 of this chapter.

State Agencies - In situations described in this chapter in which the contractor is required to submit a copy of the provider’s paper Form CMS-855 to the state agency, the contractor shall send a copy of the ADR in lieu of the Form CMS-855 if the provider sent in its application via the Internet.

15.16 – Ordering/Certifying Suppliers Who Do Not Have Medicare Billing Privileges

(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)

15.16.1 – Ordering/Certifying Suppliers – Background

(Rev. 532, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

A. Who Can Order/Certify

Generally, depending upon state law, the following physicians and non-physician practitioners are permitted to order or certify items or services for Medicare beneficiaries:

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry
- Doctors of optometry
- Physician assistants
- Certified clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Certified nurse midwives
- Clinical social workers

Most physicians and non-physician practitioners enroll in Medicare so they can receive reimbursement for covered services to Medicare beneficiaries. However, some physicians and non-physician practitioners who are not enrolled in Medicare via the Form CMS-855I may wish to order or certify items or services for Medicare beneficiaries. These individuals can become eligible to do so by completing the Form CMS-855O via paper or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) process.

NOTE: It is important to observe that physicians and non-physician practitioners that complete the Form CMS-855O do not and will not send claims to a Medicare contractor for services they furnish. They are not afforded Medicare billing privileges for the purpose of submitting claims to Medicare directly for services that they furnish to beneficiaries. Such persons may be:

- Employed by the Department of Veterans Affairs (DVA)
- Employed by the Public Health Service (PHS)
- Employed by the Department of Defense (DOD) Tricare
- Employed by the Indian Health Service (IHS) or a tribal organization
- Employed by a federally qualified health center (FQHC), rural health clinic (RHC), or critical access hospital (CAH)

- Licensed residents and physicians in a fellowship (see subsection B)
- Dentists, including oral surgeons
- Pediatricians

B. CMS Final Rule 6010-F

CMS-6010-F was published in the Federal Register on April 27, 2012. It set forth and/or reiterated several policies including, but not limited to, the following:

1. Residents (as defined in 42 CFR § 413.75 and which includes interns and fellows) who are enrolled in an accredited graduate medical education program in a state that licenses or otherwise enables such individual to practice or order these items or services may enroll in Medicare to order and certify.
2. To order and certify for Medicare items and services, a provider or supplier must be enrolled in either PECOS or the Medicare contractor's legacy system.
3. The ordering/certifying provisions of the final rule only apply to items of durable medical equipment, prosthetics, orthotics and supplies, imaging and clinical laboratory services, and home health services.

An interim final rule – CMS-6010-IFC, which was published in the Federal Register on May 5, 2010 – used the terms “refer” and “referring,” rather than “certify” and “certifying.” The April 27, 2012 final rule stated that the latter two terms should be used instead of “refer” and “referring.”

15.16.2 – Processing Initial Form CMS-855O Submissions (Rev. 532, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

The instructions in sections 15.7 through 7.1.6.2 of this chapter take precedence over those in sections 15.16.2 and 15.16.3.

A. Receipt

Upon receipt of an initial Form CMS-855O (or - for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) submissions - a certification statement), the contractor shall create a logging & tracking (L & T) record.

NOTE: The physician/non-physician practitioner need not submit a Form CMS-460, a Form CMS-588, or an application fee with his or her Form CMS-855O.

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the form in accordance with the instructions outlined in that section.

B. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify all of the information on the Form CMS-855O. This includes, but is not limited to:

- Verification of the individual's name, date of birth, social security number, and National Provider Identifier (NPI).
- Verification that the individual meets the requirements for his/her supplier type. (The contractor reserves the right to request that the individual submit documentation verifying his or her professional licensure, credentials, or education.)
- Verification that the individual is of a supplier type that can legally order or certify.
- Reviewing the Medicare Exclusion Database (MED) and System for Award Management (SAM) to ensure that the individual is not excluded or debarred.

If, at any time during the verification process, the contractor needs additional or clarifying information from the physician/non-physician practitioner, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

C. Disposition

Upon completion of its review of the form, the contractor shall approve, deny, or reject it.

Grounds for denial are as follows:

- The supplier is not of a type that is eligible to use the Form CMS-855O.
- The supplier is not of a type that is eligible to order or certify items or services for Medicare beneficiaries.
- The supplier does not meet the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the MED and/or debarred per the SAM.

If the contractor believes that another ground for denial exists for a particular submission, it should contact its CMS Provider Enrollment Business Function Lead

for guidance.

The Form CMS-855O may be rejected if the supplier fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the Form CMS-855O submission, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter to the supplier notifying him or her of the denial or rejection and the reason(s) for it. The letter shall follow the formats outlined in sections 15.24.22 (rejections) and 15.24.23 (denials) of this chapter. Denial letters shall be sent via certified mail. Rejection letters shall be sent by mail or e-mail. (**NOTE:** A denial triggers appeal rights. A rejection does not.)

If the Form CMS-855O is approved, the contractor shall: (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval. The letter shall follow the format outlined in section 15.24.21 of this chapter.

E. Miscellaneous

NOTE: The contractor shall observe the following:

1. The supplier shall be treated as a non-participating supplier (or "non-par").
2. If the supplier is employed by the DVA, the DOD, or the IHS, he or she – for purposes of the Form CMS-855O - need only be licensed or certified in one State. Said State need not be the one in which the DVA or DOD office is located.
3. Nothing in sections 15.16.2 through 15.16.4 affects any existing CMS instructions regarding the processing of opt-out affidavits.
4. Suppliers cannot submit an abbreviated version of the Form CMS-855I in lieu of the Form CMS-855O.
5. The effective date of enrollment shall be the date on which the contractor received the paper form or Web-based certification statement in its mailroom.
6. If the supplier's Form CMS-855O has been approved and he or she later wants to obtain Medicare billing privileges, he or she must voluntarily withdraw his or her Form CMS-855O enrollment prior to receiving Medicare billing privileges. (The supplier, of course, must complete the Form CMS-855I in order to receive Medicare billing privileges.)

15.16.3 – Processing Form CMS-855O Change of Information Requests

(Rev. 532, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

A. Receipt

Upon receipt of a Form CMS-855O change of information request (or - for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) change requests - a certification statement), the contractor shall create a logging and tracking (L & T) record.

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the change request via the instructions outlined in that section.

Suppliers who are enrolled in Medicare via the Form CMS-855I may not report changes to their enrollment information via the Form CMS-855O. They must use the Form CMS-855I. Similarly, suppliers whose Form CMS-855O submissions have been approved must use the Form CMS-855O to report information changes; they cannot use the Form CMS-855I for this purpose.

B. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify the new information that the supplier furnished on the Form CMS-855O. (This includes checking the supplier against the Medicare Exclusion Database and the System for Award Management (SAM).) If, at any time during the verification process, the contractor needs additional or clarifying information, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

C. Disposition

Upon completion of its review of the change request, the contractor shall approve, deny, or reject the submission. The principal ground for denial will be that the new information was furnished, but could not be verified. If the contractor believes that another ground for denial exists with respect to a particular submission, it should contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

The change request may be rejected if the supplier failed to furnish all required information on the form within 30 calendar days of the contractor's request to do so. The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the change request, the contractor shall: (1) switch the PECOS record to a “denied” or “rejected” status (as applicable), and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the denial or rejection and the reason(s) for it.

If the change request is approved, the contractor shall (1) switch the PECOS record to an “approved” status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval.

15.16.4 – Form CMS-855O Revocations (Rev. 532, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

If the contractor determines that grounds exist for revoking the supplier’s Form CMS-855O enrollment, it shall:

- Switch the supplier’s Provider Enrollment, Chain and Ownership System (PECOS) record to a “revoked” status,
- End-date the PECOS record, and
- Send a letter via certified mail to the supplier stating that his or her Form CMS-855O enrollment has been revoked. The letter shall follow the format outlined in section 15.24.24 of this chapter.

Grounds for revoking the supplier’s Form CMS-855O enrollment are as follows:

- The supplier is no longer of a type that is eligible to order or certify.
- The supplier no longer meets the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the Medicare Exclusion Database (MED) and/or debarred per the System for Award Management (SAM).

For purposes of the Form CMS-855O only, the term “revocation” effectively means that:

- The supplier may no longer order or certify Medicare services based on his or her having completed the Form CMS-855O process.
- If the supplier wishes to submit another Form CMS-855O, he or she must do so as an initial applicant.

There are appeal rights associated with the revocation of a supplier’s Form CMS-855O enrollment.

15.16.5 – Conversion from Form CMS-855O to Form CMS-855I – PECOS Requirements

(Rev. 474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

Internet-based PECOS permits an individual provider to convert his or her current Form CMS-855O application to a Form CMS-855I enrollment and vice versa. Such providers shall follow the current process for creating a new application. When PECOS detects existing approved enrollments, the provider will be prompted to select from a list of those enrollments that will be used to pre-populate the information for the new application. The provider must confirm that he or she wants to withdraw the existing enrollments before the new application may be submitted.

The enrollments to be withdrawn are displayed in a new section of the ADR in PECOS Administrative Interface (AI). The contractor shall review this information and take the appropriate action to voluntarily withdraw the enrollments listed. The contractor shall begin working the Form CMS-855I enrollment but leave it in “In Review” status while withdrawing the other enrollments. A logging and tracking (L&T) submittal reason of Voluntary Termination shall be used to withdraw the Form CMS-855O enrollment. The effective date of the withdrawn enrollments shall be one day prior to the effective date of the Form CMS-855I enrollment. If it is determined that the Form CMS-855O enrollment requiring withdrawal is outside of the contractor’s jurisdiction, the contractor shall notify the other contractor via email using the “Associate Profile Contact List,” stating that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and include the email in its files as documentation.

If the provider submits a paper Form CMS-855I application and it is determined that a current Form CMS-855O enrollment exists within the contractor jurisdiction, the contractor shall voluntarily withdraw the Form CMS-855O enrollment. If it is determined that the current Form CMS-855O enrollment is outside of the contractor’s jurisdiction, the contractor shall notify the other contractor via email using the “Associate Profile Contact List” that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and include the email in its files as documentation.

If the provider submits a paper Form CMS-855O to voluntarily withdraw his or her enrollment as well as a paper Form CMS-855I to begin billing Medicare, the contractor shall not contact the provider to confirm the submissions unless the contractor has reason to believe that what was submitted was not the provider’s intention. If it is determined that the provider submitted applications to convert his or her existing Form CMS-855O enrollment into a Form CMS-855I enrollment in error (either via paper or Internet-based PECOS), the contractor shall reject the application, thus returning the enrollment record back to its previous state.

15.16.6 – Form CMS-855O Processing Guide

(Rev. 773, Issued: 02-23-18, Effective: 03-23-18, Implementation: 03-23-18)

Go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending> to view the CMS-855O Processing Guide, which constitutes a general Form CMS-855O processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855O, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855O applications.

15.17 – Establishing an Effective Date of Medicare Billing Privileges

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

(This section applies to the following individuals and organizations: physicians; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, physical therapists, occupational therapists; physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above; and ambulance suppliers.)

A. Background

In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above is the later of:

- The date the supplier filed an enrollment application that was subsequently approved, or
- The date the supplier first began furnishing services at a new practice location.

NOTE: The date of filing for Form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.

B. Retrospective Billing

Consistent with 42 CFR §424.521(a), the individuals and organizations identified above may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements, and
- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the phrase “circumstances precluded enrollment” to mean that the supplier meets all program requirements including state licensure) during the 30-day period before an application was submitted and no final adverse action, as identified in § 424.502, precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for a determination on this issue.

C. Legal Distinction between Effective Date of Enrollment and Retrospective Billing Date

The effective date of enrollment is “the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location.” The retrospective billing date, however, is “up to...30 days prior to (the supplier’s) effective date (of enrollment).” To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a paper Form CMS-855I initial enrollment application on May 1; the contractor receives the application on May 4. The application is approved on June 1. The physician’s effective date of enrollment is May 4, which is the later of (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 4 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR § 424.521(a) are met.

Hence, the effective date entered into PECOS and the Multi-Carrier System will be April 4; claims submitted for services provided before April 4 will not be paid.

15.17.1 - Effective Date for Certified Providers and Certified Suppliers

(Rev. 404, Issued: 01-20-12, Effective: 04-22-12, Implementation: 04-22-12)

The final Fiscal Year (FY) 2011 Hospital Inpatient Prospective Payment System (IPPS) final rule was published on August 16, 2010 (75 FR 50042) and became

effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification responsibility.

Section 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 was revised to clarify that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met. Such requirements include the Medicare contractor's review and verification of the provider/supplier's Form CMS-855 application.

These clarifications were necessary because of a September 28, 2009 decision of the Appellate Division of the Department Appeals Board (DAB). The DAB's interpretation of §489.13 was that it did not include enrollment application processing as among the Federal requirements that must be met. In that case, a State Agency (SA) had conducted a survey of an applicant on July 6, 2007, prior to receiving the November 21, 2007 notice from the Medicare contractor that was recommending approval of the applicant's enrollment application. The CMS Regional Office (RO) issued a provider approval effective November 21, 2007, consistent with our traditional interpretation of §489.13. The DAB, however, ruled that the effective date must be July 6, 2007. The DAB agreed with the applicant that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the provider to meet [under §489.13], but rather a requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

Although SAs and accreditation organizations (AOs) are aware that - in accordance with Section 2003B of the State Operations Manual (SOM) - they should not perform a survey of a new facility until the Medicare contractor has made a recommendation for approval, circumstances do occur where the sequence is reversed. AOs, in particular, often find it challenging to confirm whether the Medicare contractor has made its recommendation. This is because AOs are dependent upon the applicant providing copies of the pertinent notices. When the survey occurs prior to the enrollment verification activities, we believe it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date on which the contractor determined that the enrollment application verification.

Accordingly, §489.13(b) now states that:

“Federal requirements include, but are not limited to –

- (1) Enrollment requirements established in part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

- (2) The requirements identified in §§489.10 and 489.12; and
- (4) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.”

15.17.2 - Effective Date for MDPP Suppliers

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

In accordance with 42 CFR §424.205(f), the effective date for billing privileges for MDPP suppliers is the later of:

- The date the supplier filed an enrollment application that was subsequently approved,
- The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
- The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.

Under no circumstances should an effective date for billing privileges be prior to April 1, 2018. For any Form CMS-20134 that were submitted prior to April 1, 2018 and subsequently approved, the contractor shall note April 1, 2018 as the MDPP supplier’s effective date, even if this date is in the future.

NOTE: The date of filing for paper Form CMS-20134 applications is the date on which the contractor received the application. For Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, the date of filing is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

15.18 – Ordering and Certifying Documentation - Maintenance Requirements

(Rev. 587, Issued: 04-17-15, Effective: 07-20-15, Implementation: 07-20-15)

A. Background

Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation (see next paragraph) for 7 years from the date of service, and

- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

In addition, under §424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke enrollment under §424.535(a)(10).

B. Justification for Request for Documentation

Absent a CMS directive to the contrary, the contractor shall request the documentation described in subsection (A) if it has reason to believe that the provider, supplier, physician or eligible professional (hereinafter collectively referred to as “provider”) is not maintaining the documentation in accordance with §424.516(f)(1) or (2). Examples of when a request might be appropriate include, but are not limited to:

- The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has generated an alert with respect to the provider.
- The provider has been the subject of a recent Zone Program Integrity Contractor referral.
- The provider maintains an elevated surety bond amount.

These are, of course, only examples of when a request could perhaps be warranted. Ultimately, the contractor would have to consider the surrounding circumstances of each case, including those involving situations not addressed in the aforementioned examples. The contractor may always contact its CMS Provider Enrollment Business Function Lead (PEBFL) if it is uncertain as to whether a particular

documentation request should be made.

NOTE: Documentation cannot be requested for written orders and certifications dated prior to July 6, 2010.

C. Maintaining and Providing Access to Documentation

Under §424.516(f), CMS or a Medicare contractor may request access to documentation described in §424.516(f). The term “access to documentation” means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor. All providers and suppliers who either furnish, order, or certify the items described in section A above are subject to this requirement and are individually responsible for maintaining these records and providing them upon request.

For example, if a Medicare contractor requests copies of all orders for wheelchairs from an ordering physician for all beneficiaries with dates of service from November 1, 2014 through November 10, 2014, the ordering physician must provide the copies, in full, according to the specific request. If copies cannot be provided because the physician or eligible professional did not personally maintain the records or can only be partially provided, then the requirement to maintain this documentation and provide access to it will not have been met and the provider, supplier, physician, or eligible professional may be subject to the revocation basis set forth in §424.535(a)(10).

Examples of Sufficient and Deficient Access may include, but are not limited to:

| Sufficient Access | Deficient Access |
|--|--|
| <ul style="list-style-type: none">• All documentation requested | <ul style="list-style-type: none">• Providing none of the requested documentation |
| <ul style="list-style-type: none">• Documentation specific to the order(s) or certification(s), as requested | <ul style="list-style-type: none">• Providing only a portion of the requested documentation |
| <ul style="list-style-type: none">• Documentation for the dates of service or billing periods requested | <ul style="list-style-type: none">• Providing similar documentation that does not contain the order or certification requested |
| | <ul style="list-style-type: none">• Providing other documents NOT requested by CMS or a Medicare contractor and/or not specifically directing attention to the requested documentation |

CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf. However, it remains the responsibility of the individual or entity upon whom/which the request has been

made to provide documentation. All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with not complying with the documentation request.

D. Process

If the contractor believes that a request for documentation is warranted, it shall prepare and send a request letter to the provider via mail. If the provider:

- Fails to respond within 30 calendar days of the contractor's request (i.e., a complete non-response), the contractor shall revoke enrollment using §424.535(a)(10) as the basis. Prior approval from the contractor's PEOG BFL is not necessary. A 1-year re-enrollment bar shall be imposed.
- Timely furnishes documentation that the contractor nevertheless deems inadequate, the contractor shall send a developmental letter via mail, e-mail or fax to the provider that requests more sufficient documentation. If the provider fails to submit such documentation (either via a complete non-response or by submitting additional inadequate documentation), the contractor shall refer the matter (including the documentation submitted to date) to its CMS PEBFL. CMS will determine whether a revocation is warranted and will notify the contractor via e-mail of its decision.
- Furnishes documentation that the contractor deems adequate, the contractor need not take further action other than to place the documentation and the documentation request letter(s) in the provider file.

E. Additional Guidance

The contractor shall also abide by the following:

1. When preparing the letter referred to in (C)(1) above, the contractor shall use the appropriate model language in (E) or (F) below. Note, however, that while the letters request copies of orders, the contractor has the discretion to ask for different or additional documentation (e.g., documentation that supports the legitimacy of a particular service or the payment of a particular claim). Copies of orders need not be requested in every situation. As alluded to in (B) above, the contractor would have to examine the facts of each case in determining the type(s) of documentation to be requested.
2. There may be situations in which CMS directs the contractor to request documentation in a particular case. The contractor shall follow the instructions in this section 15.18 with respect to doing so.
3. The contractor shall contact its CMS PEBFL if it has questions as to whether

particular submitted documentation is adequate or legitimate – specifically, whether it falls within the category of documentation described in section (A) above.

F. Model Language for § 424.516(f)(1) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in §424.516(f)(1).

“Dear Provider/Supplier:

Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service, and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(1), please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries’ names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the provider or supplier furnished the items/services in question. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10).”

G. Model Language for §424.516(f)(2) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in § 424.516(f)(2).

“Dear Physician/Professional:

Under 42 CFR §424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(2), please mail to us copies of the orders for items or services that you issued for the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries’ names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the orders were made. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10).” (For individuals enrolled via the Form CMS-855O, the contractor shall instead use the following language: “Failure to timely submit this documentation may result in the revocation of your Form CMS-855O enrollment.”)

15.19 – Application Fees and Additional Screening Requirements (Rev 371, Issued: 03-23-11, Effective: 03-25-11, Implementation: 03-25-11)

15.19.1 – Application Fees (Rev. 824; Issued: 09-05-18; Effective: 10-01-18; Implementation: 10-01-18)

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 (regardless of whether the revalidation application was requested by CMS or voluntarily submitted by the provider or supplier), 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-20134, Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. 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 was \$505.00. The fee for January 1, 2016 through December 31, 2016 is \$554.00. 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 <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>, either via credit card, debit card, or check.

Also, with respect to the application fee requirement:

- The fee is based on the Form CMS-855 or Form CMS-20134 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 or Form CMS-20134 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 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

CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). CMS 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. 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 BFL. Ultimately, it is the provider’s responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

D. Receipt

If an application fee is required 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.
- 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.
 - 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 BFL. If CMS:
 - 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 determine whether the fee has been submitted via Pay.gov.

- b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied); or
- 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 BFL. As the fee has been paid, the contractor shall begin processing the application as normal.

E. Year-to-Year Transition

There may be isolated instances where, at the end of a calendar year, an institutional provider pays the fee amount for that year (Year 1), yet the submission date (for Internet-based PECOS applications) or the application postmark date (for paper applications) falls in the beginning of the following year (Year 2). Assuming that Year 2's fee is higher than Year 1's, the provider will be required to pay the Year 2 fee. The contractor shall not begin processing the application until the entire fee amount has been paid. Accordingly, the contractor shall (1) send an e-mail to its PEOG BFL requesting a full refund of the fee and including any pertinent documentation in support of the request, and (2) send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the correct fee amount (i.e., the Year 2 amount) 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.

F. Appeals of Hardship Determinations

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

1. If the provider is dissatisfied with CMS' decision to deny a hardship exception request, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination (e.g., CMS' 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 & Oversight 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.

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

- (a) Conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request.
- (b) Based on CMS' review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, CMS will send a letter to the provider or supplier to acknowledge receipt of its request. In its acknowledgment letter, CMS 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 CMS denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If CMS 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. If the application has already been rejected, request that the provider resubmit the application without the fee.

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.

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.

G. 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. (This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.) 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. For MDPP suppliers, which have administrative locations and not practice locations, the application fee must only be paid upon initial enrollment and revalidation, and not when an additional administrative location is being added to an initial 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, Form CMS- 855S, or Form CMS-20134. (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 unless the provider had been deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.
- Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

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 15.19.1(D).
- Notify the applicant of the rejection or denial in accordance with section 15.19.1(D).

5. Refund Requests – Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For credit card refunds, the provider shall include its Pay.gov receipt or the Pay.gov tracking ID number; if the fee was paid via ACH Debit, a W-9 is required.

15.19.2 – Screening Categories

(Rev. 371, Issued: 03-23-11, Effective: 03-25-11, Implementation: 03-25-11)

15.19.2.1 – Background

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

Consistent with 42 CFR § 424.518, newly-enrolling and existing providers and suppliers will, beginning on March 25, 2011, be placed into one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor’s screening of the provider when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

A. Limited

The “limited” level of categorical screening consists of the following provider and supplier types:

- Physicians
- Non-physician practitioners other than physical therapists
- Physician group practices
- Non-physician group practices other than physical therapist group practices
- Ambulatory surgical centers
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease facilities
- Federally qualified health centers
- Histocompatibility laboratories
- Hospitals (including critical access hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities).
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Outpatient physical therapy/outpatient speech pathology providers enrolling via the Form CMS-855A
- Pharmacies that are newly enrolling or revalidating via the Form CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics
- Skilled nursing facilities

For providers and suppliers in the “limited” category, the contractor shall (unless section 15.19.2.5 of this chapter applies) process initial, revalidation, and new location applications in accordance with existing instructions.

B. Moderate

The “moderate” level of categorical screening consists of the following provider and supplier types:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRSSs)
- Revalidating home health agencies (HHAs)
- Revalidating DMEPOS suppliers
- Revalidating MDPP suppliers

For providers and suppliers in the “moderate” level of categorical screening, the contractor shall (unless section 15.19.2.2 of this chapter or another CMS directive applies):

1. Process initial, revalidation, and new location applications in accordance with existing instructions; and
2. Except for revalidating DMEPOS suppliers, order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) in accordance with sections 2(a) through (e) below. The site visit, which the National Site Visit Contractor (NSVC) will perform, is to ensure that the supplier is in compliance with CMS’s enrollment requirements. Unless stated otherwise in this chapter, the scope of the site visit will be consistent with section 15.19.2.2.
 - a. Ambulance suppliers, independent clinical laboratories, physical therapists, and physical therapist groups
 - Initial application – If the supplier submits an initial application, the contractor shall order a site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
 - Revalidation – If the supplier submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
 - New location - The contractor shall order a site visit of the location. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
 - b. CMHCs

- Initial application - In addition to the site visit discussed in section 15.4.1.1(B)(1) of this chapter, the contractor shall order a site visit after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the CMHC. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.
- Revalidation - If the CMHC submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.
- New location - The contractor shall order a site visit of the location after the contractor receives notice of approval from the RO but before the contractor switches the provider's enrollment record to "Approved." The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. CORFs, hospices and PXRSSs

- Initial application – If the provider/supplier submits an initial application, the contractor shall order a site visit after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the provider/supplier. The contractor shall not convey Medicare billing privileges to the provider/supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.
- Revalidation – If the provider/supplier submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.
- New location - The contractor shall order a site visit of the location after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to "Approved." The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

d. IDTFs

- Initial applications – The NSVC will conduct site visits of initially enrolling IDTFs consistent with section 15.4.19.6 of this chapter.
 - Revalidations - The NVSC will conduct site visits of revalidating IDTFs (prior to the contractor’s final decision regarding the revalidation application) consistent with section 15.4.19.6 of this chapter.
 - Code Changes – The NSVC will conduct site visits for IDTF code changes as specified in section 15.4.19.6(B) of this chapter.
- e. Revalidating HHAs – If an HHA submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
- f. Revalidating DMEPOS suppliers – The National Supplier Clearinghouse (NSC) shall conduct a site visit of the DMEPOS supplier prior to making a final decision regarding the revalidation application.
- g. Revalidating MDPP Suppliers – If an MDPP supplier submits a revalidation application, the contractor shall order a site visit. The Contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

C. High

The “high” level of categorical screening consists of the following provider and supplier types:

- Newly enrolling DMEPOS suppliers
- Newly enrolling HHAs (including HHAs that must submit an initial enrollment application pursuant to § 424.550(b)(1))
- Newly enrolling MDPP suppliers

For providers and suppliers in the “high” level of categorical screening:

1. The contractor shall process the application in accordance with existing instructions; and
2. The NSVC will perform a site visit for newly enrolling HHAs and MDPP suppliers. (The NSC will perform a site visit for newly enrolling DMEPOS suppliers.) For initially enrolling HHAs, the contractor shall order a site visit via PECOS after the contractor receives the tie-in notice or approval letter from the RO but before the contractor switches the provider’s enrollment record to “Approved.” The contractor shall not switch the

provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

NOTE:

- Enrolled DMEPOS suppliers that are adding another location will be classified as "high" for screening purposes. (See section 15.19.2.3 below for information regarding DMEPOS changes of ownership and tax identification number (TIN) changes.)
- Newly-enrolling HHA sub-units fall within the "high" level of categorical screening.
- The addition of a new HHA branch falls within the "moderate" level of categorical screening. The contractor shall order a site visit of the location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider's enrollment record to "Approved." This is to ensure that the provider is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

This is the only site visit of the new HHA branch that must be performed prior to the record being switched to "Approved."

- The addition of a new MDPP supplier administrative location that does not result in a new PTAN does not require an additional site visit. Any additional MDPP supplier administrative location that results in a new PTAN, either due to being in a new jurisdiction or because of a new CDC organizational code, the contractors shall order a site visit of the location through PECOS. This is to ensure that the provider is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

branch that must be performed prior to the record being switched to "Approved."

15.19.2.2 - Scope of Site Visit

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. DMEPOS Suppliers and IDTFs

The scope of site visits of DMEPOS suppliers and IDTFs shall continue to be conducted in accordance with existing CMS instructions and guidance.

B. Other Provider and Supplier Types

For all provider and supplier types – other than DMEPOS suppliers and IDTFs – that are subject to a site visit in accordance with this section, the SVC will perform such visits consistent with the procedures outlined in sections 20 and 20.1 of this chapter. This includes the following:

- Documenting the date and time of the visit, and including the name of the individual attempting the visit;
- Photographing the provider or supplier's business for inclusion in the provider/supplier's file. All photographs will be date/time stamped;
- Fully documenting observations made at the facility, which could include facts such as: (a) the facility was vacant and free of all furniture; (b) a notice of eviction or similar documentation is posted at the facility, and (c) the space is now occupied by another company;
- Writing a report of the findings regarding each site verification; and
- Including a signed declaration stating the facts and verifying the completion of the site verification. (The sample declaration identified in section 20.1 of this chapter is recommended.)

In terms of the extent of the visit, the SVC will determine whether the following criteria are met:

- The facility is open
- Personnel are at the facility
- Customers are at the facility (if applicable to that provider or supplier type)
- The facility appears to be operational

For MDPP suppliers, the contractor shall check the above criteria as well as:

- Ensure that the facility is not a private residence
- Ensure that signage exists denoting the facility's legal business or DBA name

This will require the site visitor(s) to enter the provider or supplier's practice location/site, rather than simply conducting an external review.

If any of the 4 elements listed above are not met, the enrollment contractor will, as applicable - and using the procedures outlined in this chapter and in existing CMS instructions - deny the provider's enrollment application pursuant to §424.530(a)(5)(i) or (ii), or revoke the provider's Medicare billing privileges under §424.535(a)(5)(i) or (ii).

15.19.2.3 – Changes of Information and Ownership **(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

A. Limited

Changes of information (including additions of practice locations) submitted by providers and suppliers in the “limited” level of categorical screening shall be processed in accordance with existing instructions.

B. Moderate and High

Unless otherwise specified in this chapter or in another CMS directive, this section 15.19.2.3(B) applies to providers and suppliers in the “moderate” or “high” level of categorical screening.

1. Addition of Practice or Administrative Location

With the exception of suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), if a provider or supplier submits a Form CMS-855 request to add a practice location (including a home health agency (HHA) branch) or submits a Form CMS-20134 request to add an administrative location that results in a new PTAN:

- The contractor shall process the application in accordance with existing instructions, and
- A site visit shall be performed consistent with section 15.19.2.1 above.

(As explained earlier, a DMEPOS supplier that is adding a new practice location falls within the “high” screening category. Additionally, an MDPP supplier that is adding an administrative location that does not result in a new PTAN falls within the existing enrollment and a site visit is not required.)

2. Change of Location

a. DMEPOS Suppliers

If a DMEPOS supplier reports a change in the physical location of an existing practice location, the National Supplier Clearinghouse shall perform a site visit in accordance with existing instructions.

b. Non-DMEPOS Suppliers

If a provider or non-DMEPOS supplier reports a change in the physical location of an existing practice location, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) in accordance with the following:

- i. Ambulance service suppliers, independent clinical laboratories, independent diagnostic testing facilities, physical therapists enrolling as individuals or group practices – The contractor shall order a site visit of the changed location prior to the contractor’s final decision regarding the application. This is to ensure that the location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2 of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not make its final decision regarding the application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
- ii. Community mental health centers, comprehensive outpatient rehabilitation facilities, hospices, portable x-ray suppliers, HHAs - The contractor shall order a site visit of the changed location after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier’s enrollment record to “Approved.” This is to ensure that the location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2 of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

For purposes of this requirement:

- A change of location includes situations in which the provider/supplier is switching suite numbers or floors within a building. A site visit is required.
- If the provider/supplier’s physical location is not changing (e.g., the provider’s street name is changing but its actual office space is not), no site visit is required.

3. Change of Ownership

With the exception of DMEPOS suppliers and HHAs, if a provider or supplier undergoes a change of ownership resulting in a new tax identification number (TIN), the contractor shall:

- (1) Process the application in accordance with existing instructions, and

(2) Order a site visit through PECOS in accordance with the following:

- For ownership changes that must be approved by the RO under current CMS instructions, the site visit shall be ordered and performed after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to an "Approved" status. The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.
- For ownership changes that do not require RO approval under current CMS instructions, the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.

A DMEPOS supplier that is:

- Undergoing a change of ownership with a change in TIN falls within the "high" screening category.
- Undergoing a change of ownership with no change in TIN falls within the "moderate" screening category.
- Undergoing a change in TIN with no change in ownership falls within the "moderate screening category.

With respect to HHAs:

- For HHAs undergoing a change in majority ownership, the contractor shall – consistent with section 15.26.1 of this chapter – determine whether the provisions of 42 CFR §424.550(b)(1) and (2) apply. If the contractor determines that a change in majority ownership has occurred and that none of the exceptions in §424.550(b)(2) apply, the HHA must enroll as a new entity, in which case the newly-enrolling HHA will be placed into the "high" level of categorical screening. If the contractor determines that an exception does apply, the transaction will be subject to the "moderate" level of categorical screening; a site visit will be necessary.

In addition, if: (1) the contractor determines that one of the exceptions to the 36-month rule applies, and (2) the ownership change is one that requires a recommendation for approval to the RO, the contractor shall ensure that its recommendation letter specifies:

- That the transaction qualifies as a change in majority ownership
- The particular exception that applies.

- For HHAs reporting an ownership change that is not a change in majority ownership as that term is defined in §424.502, the contractor shall process the change in accordance with existing instructions. A site visit is not necessary.
- For HHAs seeking to reactivate their Medicare billing privileges, the transaction shall be processed under the “moderate” level of categorical screening. A site visit will be necessary prior to the reactivation of the provider’s billing privileges.

4. All Other Changes of Information

All other changes of information for providers and suppliers in the moderate or high level of categorical screening shall be processed in accordance with existing instructions.

15.19.2.4 – Reactivations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Form CMS-855 Reactivations

1. Limited

Form CMS-855 reactivation applications submitted by providers and suppliers in the “limited” level of categorical screening shall be processed in accordance with existing instructions.

2. Moderate

Form CMS-855 reactivation applications submitted by providers and suppliers in the “moderate” level of categorical screening – including existing home health agencies and suppliers of durable medical equipment, prosthetics, orthotics and suppliers (DMEPOS) – shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor’s final decision regarding the application.

3. High

Form CMS-855 or Form CMS-20134 reactivation applications submitted by providers and suppliers in the “high” level of categorical screening shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor’s final decision regarding the application.

B. Reactivation Certification Packages (RCPs)

For RCPs (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter), a site visit is required if the provider is in the moderate or high screening category. A site visit is not required if the provider is in the limited screening category.

15.19.2.5 – Movement of Providers and Suppliers into the High Level

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

Under §424.518(c)(3), CMS may adjust a particular provider or supplier's screening level from "limited" or "moderate" to "high" if any of the following occur:

1. CMS imposes a payment suspension on a provider or supplier at any time within the last 10 years;
2. The provider or supplier:
 - a. Has been excluded from Medicare by the Office of Inspector General; or
 - b. Had its billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by:
 - Enrolling as a new provider or supplier; or
 - Obtaining billing privileges for a new practice location
 - c. Has been terminated or is otherwise precluded from billing Medicaid
 - d. Has been excluded from any Federal health care program
 - e. Has been subject to any final adverse action (as defined in §424.502) within the previous 10 years.
3. CMS lifts a temporary moratorium for a particular provider or supplier type, and a provider or supplier that was prevented from enrolling based on the moratorium applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

CMS makes available to the contractor on a bi-monthly basis a list of current and former Medicare providers and suppliers within the contractor's jurisdiction that meet any of the criteria in subsection (1) or (2) above. Upon receipt of an initial or revalidation application from a provider or supplier that otherwise falls within the limited or moderate screening category (and after the appropriate fee has been paid, etc.), the contractor shall determine whether the provider or supplier is on the bi-monthly "high" screening list. If the provider or supplier is not on said list, the

contractor shall process the application in accordance with existing instructions. If the provider or supplier is on the list, the contractor shall process the application using the procedures in the “high” screening category unless the provider is on the list solely because he/she/it was revoked for failing to timely respond to a revalidation request. If such is the case, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead for guidance as to how the situation should be handled.

With respect to subsection (3) above, if the contractor receives an initial or new location application from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium and (b) within 6 months after the applicable moratorium was lifted, the contractor shall process the application using the procedures in the “high” screening category.

15.19.3 – Temporary Moratoria

(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

Under §424.570(a), CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. The announcement of a moratorium will be made via the Federal Register, though the contractor will be separately notified of the moratorium.

The contractor shall abide by all CMS directives and instructions issued pursuant to the imposition or lifting of a particular moratorium.

15.19.4 – Tracking

(Rev. 371, Issued: 03-23-11, Effective: 03-25-11, Implementation: 03-25-11)

In April 2011, PEOG will send to each contractor an Excel spreadsheet that the contractor shall complete and submit to its PEOG liaison via e-mail no later than the 15th day of each month. The first report will be due on May 15, 2011. The spreadsheet will contain data elements such as, but not limited to:

- Number of enrolled providers and suppliers in each risk category, broken down by provider/supplier sub-type (e.g., hospital, HHA)
- Amount of fees collected (i.e., fees that were cleared), broken down by provider and supplier type

15.20 – On-site Inspections and Site Verifications

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The contractor shall not conduct site verifications to determine if a provider or supplier (including physicians and non-physician practitioners) is operational unless CMS: (1) has already issued formal guidance to do so, or (2) issues instructions

directing the contractor to conduct a pre-enrollment or post-enrollment site verification.

15.20.1 - Site Verifications

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

(Unless otherwise stated in this chapter or in another CMS directive, this section 15.20.1 only applies to site visits/verifications that are not performed pursuant to sections 15.19.2.1 through 15.19.2.4 of this chapter.)

A. Background

1. Operational Status

When conducting a site verification to determine whether a practice or administrative location is operational, the contractor shall make every effort to limit its site verification to an external review of the practice location. If the contractor cannot determine whether the practice location is operational based on an external review of the location, the contractor shall conduct an unobtrusive site verification by limiting its encounter with provider or supplier personnel or medical patients.

2. Determining Whether the Provider or Supplier Meets Regulatory Requirements for Its Provider or Supplier Type

When conducting a site verification to determine whether a provider or supplier continues to meet the regulatory provisions for its provider or supplier type, the contractor shall conduct its site verification in a manner which limits the disruption for the provider or supplier.

B. Timing

Site verifications should be done Monday through Friday (excluding holidays) during their posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m. If, during the first attempt, there are obvious signs that facility is no longer operational no second attempt is required. If, on the first attempt the facility is closed but there are no obvious indications the facility is non-operational, a second attempt on a different day during posted hours of operation should be made.

C. Documentation

When conducting site verifications to determine whether a practice location is operational, the contractor shall:

- Document the date and time of the attempted visit and include the name of the individual attempting the visit;

- As appropriate, photograph the provider or supplier’s business for inclusion in the provider or supplier’s file on an as needed basis. All photographs should be date/time stamped;
- Fully document all observations made at the facility (e.g., the facility was vacant and free of all furniture, a notice of eviction or similar documentation was posted at the facility, the space is now occupied by another company); and
- Write a report of its findings regarding each site verification.

D. Signed Declaration

The contractor shall also include a signed declaration stating the facts and verifying the completion of the site verification. (A sample declaration is below and may be revised as necessary.) As a reminder, this declaration is only necessary for MAC-performed site visits.

Declaration of (Name of Inspector/Investigator)

In the Case of _____

Provider/Supplier No. _____

I, **(Name of Inspector/Investigator)**, declare as follows:

1. I have personal knowledge of each of the following matters in this Declaration except to those facts alleged on information and belief, and as to those matters, I believe them to be true. I am competent to testify to the following:
2. I am an Investigator for [Insert Contractor Name]. [Insert Contractor Name] is a CMS-contracted [Intermediary/Carrier/A/B Medicare Administrative Contractor (MAC)].
3. I have been trained as an Investigator and Site Inspector by [Insert Contractor Name], and I am knowledgeable of Medicare’s compliance statutes, regulations and standards for suppliers enrolled in the Medicare program. I have worked in this capacity for [Insert years] years. During this period, I have conducted over [Insert Number] site inspections of the offices and facilities of providers/suppliers; and since January [Year in which case occurs], I have conducted over [Insert Number] site inspections related to the compliance of suppliers with Medicare’s requirements.
4. I prepared the attached document entitled “[Title of Document],” which is the report of my attempts to inspect Petitioner’s facility. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report.

5. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this (Date) day of (Month) (Year) in (City) , (State) .

SIGNATURE OF DECLARANT

E. Determination

If a provider or supplier is determined not to be operational or not to be in compliance with the regulatory requirements for its provider/supplier type, the contractor shall revoke the Medicare billing privileges of the provider or supplier - unless the provider or supplier has submitted a change that notified the contractor of a change in practice location. Within 7 calendar days of CMS or the Medicare contractor determining that the provider or supplier is not operational, the Medicare contractor shall update PECOS or the applicable claims processing system (if the provider does not have an enrollment record in PECOS) to revoke billing Medicare billing privileges and issue a revocation notice to the provider or supplier. The Medicare contractor shall afford the provider or supplier applicable appeal rights in the revocation notification letter.

For non-operational status revocations, the contractor shall use either 42 CFR §424.535(a)(5)(i) or 42 CFR §424.535(a)(5)(ii) as the legal basis for revocation.

Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer operational. The Medicare contractor shall establish a 2-year enrollment bar for suppliers that are not operational.

For regulatory non-compliance revocations, the contractor shall use 42 CFR §424.535(a)(1) as the legal basis for revocation. Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer in compliance with regulatory provisions for their provider or supplier type. The Medicare contractor shall establish a 2-year enrollment bar for the providers and suppliers that are not in compliance with provisions for their enrolled provider or supplier type.

15.20.2 - Reserved for Future Use

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

15.20.3 - National Supplier Clearinghouse (NSC)

(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)

The (NSC) shall continue to conduct onsite inspections consistent with its Statement of Work and any instructions issued by the NSC project officer.

15.21.2 – Enrolling Indian Health Service (IHS) Facilities as DMEPOS Suppliers

(Rev. 430, 09-28-12, Effective: 10-29-12, Implementation: 10-29-12)

A. Background

The National Supplier Clearinghouse (NSC) shall enroll IHS facilities as DMEPOS suppliers in accordance with (a) the general enrollment procedures cited in chapter 15, (b) the statement of work contained in the NSC contract with Medicare, and (c) the special procedures cited in this section.

For enrollment purposes, Medicare recognizes two types of IHS facilities: (1) facilities wholly owned and operated by the IHS, and (2) facilities owned by the IHS but tribally operated or totally owned and operated by a tribe. CMS will provide the NSC with a list of IHS facilities that distinguishes between these two types.

On the list, the NSC shall use the column entitled, “FAC OPERATED BY”, for this purpose.

B. Enrollment

The provider/supplier shall complete the Form CMS-855S shall be completed in accordance with the instructions shown therein.

NOTE: Facilities that are:

- Totally owned and operated by the IHS are considered governmental organizations. An Area Director of the IHS must sign section 15 of the Form CMS–855S, be listed in section 6 of the form, and sign the letter required under section 5 of the form that attests that the IHS will be legally and financially responsible in the event there is any outstanding debt owed to CMS.
- Tribally operated are considered tribal organizations. Section 15 of the Form CMS–855S must be signed by a tribal official who meets the definition of an “authorized official” under 42 CFR § 424.502. The individual must also be listed in section 6 of the form, and must sign the letter required under section 5 of the form that attests that the tribe will be legally and financially responsible in the event there is any outstanding debt owed to CMS.

C. Supplier Standards, Exceptions and Site Visits

All IHS facilities, whether operated by the IHS or a tribe:

- Shall meet all required standards, with the exception of:
 - The comprehensive liability insurance requirements under 42 CFR 424.57(c)(10).
 - The requirement to provide State licenses for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a State that requires a bedding license, such licensure is not required. However, if it provides a DMEPOS item that requires a licensed professional in order to properly provide the item, it shall provide a copy of the professional license. The licensed professional can be licensed in any State or have a Federal license (e.g., a pharmacy does not need a pharmacy license, but shall have a licensed pharmacist).
- Shall, like all other DMEPOS suppliers, undergo site visits in accordance with section 15.19.2.1 through 15.19.2.4 of this chapter. (This includes all hospitals and pharmacies enrolling as DMEPOS suppliers.)

D. Provider Education for IHS Facilities

The NSC shall ensure that its Web site includes the information contained in this section 15.21.2 that is specific to enrollment of IHS facilities (whether operated by the IHS or a tribe).

E. Specialty Codes

The NSC shall apply the specialty code A9 (IHS) to all IHS enrollments (whether operated by the IHS or a tribe). However, the specialty code A9/A0 shall be applied to facilities that are IHS/tribal hospitals.

Other specialty codes should be applied as applicable (e.g., pharmacies).

15.21.7.1.1 – Model Letters for Claims Against Surety Bonds (Rev. 681, Issued: 10-27-16 Effective: 01-30-17, Implementation: 01-30-17)

When making a claim against a surety bond in accordance with section 15.21.7.1 of this chapter, the contractor shall use the applicable model letter below:

A. Letter for Overpayments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier National Provider Identifier (NPI)

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Supplier) has a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS - upon receiving written notice from CMS containing “sufficient evidence” as defined in the Program Integrity Manual, CMS Pub. 100-08, §15.21.7.1.A.2.(c) - the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An “unpaid claim” is defined in 42 C.F.R. §424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) has incurred an overpayment in the amount of (insert dollar amount) for (insert “a service” or “services”, as applicable) performed on (insert date(s) of service). This determination was made based on specific information about the overpayment, which is included in the attachments to this letter.

CMS has been unable to recover the full overpayment from (Supplier) using its existing recoupment procedures. (Supplier) has repaid (insert “none” or “only \$_____”) of the overpayment amount. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS’s Durable Medical

Equipment Medicare Administrative Contractor for (Supplier)'s location.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

B. Letter for Overpayments - Supplier is No Longer Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address
Former Supplier NPI

Dear Surety:

(Former Supplier legal business name) was enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Former Supplier) obtained a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An "unpaid claim" is defined in 42 C.F.R. §424.57(a) as an overpayment made by the

Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) incurred an overpayment in the amount of (insert dollar amount) for (insert “a service” or “services”, as applicable) performed on (insert date(s) of service). This determination was made based on specific information about the overpayment, which is included in the attachments to this letter.

CMS has been unable to recover the full overpayment from (Former Supplier) using its existing recoupment procedures. (Former Supplier) has repaid (insert “none” or “only \$_____”) of the overpayment amount.

(Former Supplier’s) surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. §424.57(d)(5)(iii), the surety is liable for unpaid claims that:

- (1) CMS assessed against the supplier based on overpayments that took place during the term of the bond or rider, and
- (2) Were assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier’s Medicare enrollment was terminated, whichever is later.

The overpayment occurred on (insert date), which was within the period of (Former Supplier)’s surety bond coverage with your company. Moreover, CMS has made its overpayment determination within the 2-year period following the date of the termination of (Former Supplier)’s Medicare enrollment. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS’s Durable Medical Equipment Medicare Administrative Contractor for (Supplier)’s location.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name’s] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact

_____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

C. Letter for Civil Monetary Penalties and Assessments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier NPI

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Supplier) has a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety’s liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language.....)

A CMP is defined in §424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. §402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG)) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003) to impose on a supplier as a penalty.

OR

An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Supplier) on (date) in the amount of (\$ ____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Supplier) using its existing collection procedures. (Supplier), however, has repaid (insert "none" or "only \$____) of this amount. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare and Medicaid Services.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

D. Letter for Civil Monetary Penalties and Assessments – Supplier is No Longer Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address
Former Supplier NPI

Dear Surety:

(Former Supplier legal business name) was enrolled in Medicare as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than \$50,000. In accordance with this provision, (Former Supplier) obtained a \$_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety’s liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language.....)

A CMP is defined in §424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. §402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003)) to impose on a supplier as a penalty.

OR

An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Former Supplier) on (date) in the amount of (\$ _____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter.

(Attach copy of notice of CMP/assessment that was sent to former supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Former Supplier) using its existing collection procedures. (Former Supplier), however, has repaid (insert “none” or “only \$_____”) of this amount.

(Former Supplier)’s surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. §424.57(d)(5)(iii), the surety is liable for CMPs and/or assessments that:

- (1) CMS or OIG imposed or asserted against the supplier during the term of the bond or rider, and
- (2) Were imposed or assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier’s Medicare enrollment was terminated, whichever is later.

The (CMP and/or assessment) was based on events that occurred (insert relevant date(s)), which was within the period of (Former Supplier’s) surety bond coverage with your company. Moreover, CMS imposed the (CMP and/or assessment) within the 2-year period following the date of the termination of (Former Supplier)’s Medicare enrollment. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare & Medicaid Services.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name’s] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

E. Surety Non-Payment Letter

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier National Provider Identifier (NPI)

Dear Surety:

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), we sent you a letter dated (date of letter) requesting that you make payment to CMS in the amount of (insert applicable amount) no later than 45 days from the date of said letter, a copy of which is attached. (Attach a copy of the demand letter.) As payment has not been received, this matter may be referred for further action to the United States Department of Justice for collection and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

15.22 – Customer Service/Outreach
(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

15.22.1 – Web Sites
(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at <http://www.cms.hhs.gov/MedicareProviderSupEnroll> . The link shall: (1)

be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Web site Standards and Guidelines posted on CMS's Web site.

The CMS Provider/Supplier Enrollment Web site, <http://www.cms.hhs.gov/MedicareProviderSupEnroll>, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Web site, and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Web site that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis (specifically, no later than the 15th day of January, April, July, and October), each contractor shall review and provide updates regarding its contact information shown at URL:

http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead.

15.22.2 – Provider Enrollment Inquiries

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., “Has the contractor finished processing my application?”) (The contractor may wish to establish electronic mechanisms by

which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR).

- Furnishing information on where to access the Form CMS-855 or Form CMS-20134 applications (and other general enrollment information) on-line
- Explaining to providers/suppliers which Form CMS-855 or Form CMS-20134 applications should be completed.

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 and Form CMS-20134 applications.

15.23 – Document Retention

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

15.23.1 - Security

(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes, in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Additionally, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

Note that these instructions are in addition to, and not in lieu of, all other instructions issued by CMS regarding security.

15.23.2 – Release of Information

(Rev. 762, Issued: 12-29-17, Effective: 01-29-18, Implementation: 01-29-18)

On October 13, 2006, CMS published System of Records Notice for the Provider

Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider’s organization other than the provider’s authorized official(s) (section 15 of the CMS-855), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.
- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider’s letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person’s signature. The letter can be mailed, faxed, or emailed to the contractor.
- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

- The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier’s enrollment record as a contact person:

Revalidation status (i.e., whether or not a provider/supplier has been revalidated), revalidation due date, revalidation approval date, the specific information related to a revalidation development request, and the date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.
- The contractor may not send PECOS screen printouts to the provider.

- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

15.23.3 – File Maintenance

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

The contractor shall maintain and store all documents relating to the enrollment of a provider into the Medicare program. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of Federal, State and/or local (city/county) professional licenses, certifications and/or registrations;
- Copies of Federal, State, and/or local (city/county) business licenses, certifications and/or registrations;
- Copies of professional school degrees or certificates or evidence of qualifying course work;
- Copies of CLIA certificates and FDA mammography certificates;
- Copies of any entry found on the Medicare Exclusion Database (MED) report that leads to a provider or supplier's revocation, and;
- Copies of Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) recognition letters or certificates indicating Full or MDPP preliminary recognition.

The contractor shall dispose of the aforementioned records as described below:

- 1) Provider/Supplier and Durable Medical Equipment Supplier Application
 - a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.
 - b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

- c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

- d. Approved application of provider/supplier, but the billing number was subsequently revoked.

Disposition: Destroy 15 years after the billing number is revoked.

- e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

- f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2) Electronic Mail and Word Processing System Copies

- a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

- b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete

15.24 – Model Letter Guidance

(Rev. 762, Issued: 12-29-17, Effective: 01-29-18, Implementation: 01-29-18)

A. Format Requirements

All letters sent by contractors to providers and suppliers shall consist of the following format:

- The CMS logo (2012 version) displayed per previous CMS instructions.
- The contractor's logo shall be displayed however the contractor deems

appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.

- All text, with the exception of items in the header or footer, shall be written in Times New Roman 12 point font.
- All dates in letters, except otherwise specified, shall be in the following format: month dd, yyyy (e.g., January 26, 2012).

Any exceptions to the above must be approved by the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL).

Letters shall contain fill-in sections as well as static, or "boilerplate" sections. The fill-in sections are delineated by words in brackets in italic font in the model letters.

- The contractor shall populate the fill-in sections with the appropriate information such as primary regulatory citation and specific denial and revocation reasons, names, addresses, etc.
- The fill-in sections shall be indented ½ inch from the normal text of the letter.
- All specific or explanatory (not primary CFR citations) reasons shall appear in **bold type**.
- There may be more than one primary reason listed.
- The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing State survey language for certain provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

The following do not require PEOG BFL approval:

- Placing a reference number or numbers between the provider/supplier address and the salutation.
- Appropriate documents attached to specific letters as needed.
- Placing language in any letter regarding self-service functions such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

The contractor shall use the following model letter formats. Unless as stated

otherwise in this chapter, any exceptions to these formats must be approved by the contractor's PEOG BFL.

The above format, with the exception of static and fill-in sections, shall also be used for "as needed" letters (such as letters for individual provider or supplier circumstances).

B. Sending Letters

1. The contractor shall issue approval letters within 5 business days of approving the enrollment application in PECOS.
2. The approval letter shall be sent to the contact person listed on the application via scanned email, fax or mail. If there is no contact person on file, the approval letter shall be sent to the provider or supplier at the email or mailing address provided in the correspondence address section.
3. For all applications other than the Form CMS-855S, the contractor shall send development/approval letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the email or mailing address provided in the correspondence address or special payments address sections. The National Supplier Clearinghouse shall continue to send letters to the supplier's correspondence address until their automated process can be updated to include the contact person as a recipient of the letters.

C. Reactivation Letters

If a provider or supplier is to experience a gap in billing due to failure to respond to a revalidation request or failure to respond to a development request during revalidation, the contractor shall include the following in the reactivation approval letter:

- While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing [to timely submit your revalidation application or to respond to a development request related to a revalidation application]. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.

15.24.1 – Model Acknowledgement Letter

(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

(This letter is optional)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference ID: (Case #, Control Number, etc.)

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date] and [is/are] currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional provider/supplier identification information: NPI, DBA Name, etc.

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM]

Sincerely,

[Name]
[Title]
[Company]

15.24.1.1 – Acknowledgement Letter Example
(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

June 27, 2012

Timothy Payne, M.D.
1234 Anywhere Street
Elkhart MT 87321

Reference ID: (Case #, Control Number, etc.)

Dear Timothy Payne, M.D.:

Your Medicare enrollment application(s) was received on June 1, 2012 and is currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional provider/supplier identification information: NPI, DBA Name, etc.

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at 555-555-

1212 between the hours of 8:00 AM and 5:00 PM. Sincerely,

William Boatwright
Applications Analyst
Medicare Administrative Contractor, Inc.

15.24.2 – Development Letter Guidance

(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

A. In the following sentence:

“Please submit the requested revisions and/or supporting documentation preferably within xx days of the postmarked date of this letter to the address listed below:”

The value in “xx” may be from **7** to **30**.

B. Items such as checklists and documents may be attached to the letter.

15.24.2.1 – Model Development Letter

(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

We have received your Medicare enrollment application(s). We may reject your application(s) if you do not furnish complete information within 30 calendar days from the postmarked date of this letter pursuant to 42 CFR §424.525. In order to complete processing your application(s), please make the following revisions and/or supply the requested supporting documentation:

[Specify revisions and/or supporting documentation needed]

Please submit the requested revisions and/or supporting documentation within xx days of the postmarked date of this letter to the address listed below:

[Name of MAC]

[Address]

[City], ST [Zip]

Finally, please attach a copy of this letter with your revised application(s). If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM.]

Sincerely,

[Name]
[Title]
[Company]

15.24.3 – Model Rejection Letter
(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) on [date]. We are rejecting your application(s) for the following reason(s):

[List all reasons for rejection]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

In compliance with Federal regulations found at 42 CFR §424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information.

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

[Name of MAC]

[Address]

[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

15.24.4 – Model Returned Application Letter

(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

[List all reasons for return]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.
2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

[Name of MAC]
[Address]
[City], ST [Zip]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.5 – Model Revalidation Letter
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by [**Due date, as Month dd yyyy**]. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy**]**

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "[CR 7350](#)" or "[Fee Matrix](#)".

If you need help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.1 – Model Revalidation Letter – CHOW Scenario Only
(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER NAME

NPI:

ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

PTAN:

Dear Provider/Supplier Name:

**THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION
REQUEST**

**IMMEDIATELY SUBMIT AN UPDATED
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO
VALIDATE YOUR ENROLLMENT INFORMATION**

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the CMS Regional Office (RO) and the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the CMS RO and the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at <https://www.cms.gov/MedicareProviderSupEnroll/>. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,
[Your Name]
[Title]

**15.24.5.2 – Model Large Group Revalidation Notification Letter
(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)**

[Month Day & Year]

PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Group Name:

THIS IS NOT A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

15.24.5.3 – Model Revalidation Pend Letter

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

PAYMENT HOLD

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

How to resume your payments

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** [PECOS](https://PECOS.cms.hhs.gov) is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

15.24.5.4 – Model Revalidation Deactivation Letter
(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

STOPPING BILLING PRIVILEGES

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | NPI [NPI] | PTAN [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] |
<Repeat for other reassignments>

CMS lists the records that need revalidating at
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation

as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help

Visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name] [Title] [Company]

**15.24.5.5 – Model Revalidation Past-Due Group Member Letter
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

REVALIDATION | Past-Due Group Member

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What your group member needs to do

Revalidate their Medicare enrollment record, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- **Online:** [PECOS](https://pecos.cms.hhs.gov) is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

[Name], [Title]

15.24.5.6 – Model Deactivation Letter due to Inactive Provider/Supplier Letter

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

STOPPING BILLING PRIVILEGES

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

We have stopped your Medicare billing privileges on [deactivation date], due to inactivity. We will not pay any claims after this date.

What record has been deactivated

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments:

[Legal Business Name] | [dba Name]

<Repeat for other reassignments>

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

How to recover your billing privileges

Reactivate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134]for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit go.cms.gov/MedicareRevalidation

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.7 – Model Return Revalidation Letter

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

RETURN REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
 - An unsolicited revalidation is one that is received more than seven months prior to the provider/suppliers due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
 - To find the provider/suppliers revalidation due date, please go to <http://go.cms.gov/MedicareRevalidation>.

- If you are not due for revalidation in the current six month period, you will find that your due date is listed as “TBD” (or To Be Determined). This means that you do not yet have a due date for revalidation within the current six month period. This list will be updated monthly.
- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark ‘change’ in section 1 of the [form CMS-855 or Form CMS-20134].
- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS).
Go to: <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

If you need help

Visit <http://go.cms.gov/MedicareRevalidation>, or
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.6 – Model Approval Recommended Letters
(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

15.24.6.1 – Initial Enrollments Requiring Referral to the State
(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your Medicare enrollment application and has forwarded it to [Name of State Office]. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). [If – and only if - a survey or accreditation is required, include the following language: “The next step will be a survey conducted by a State Survey Agency or a CMS approved deemed accrediting organization to ensure compliance with the required conditions of (insert “participation” or “coverage,” as applicable.)] After the CMS Regional Office determines whether all conditions of (insert “participation” or “coverage,” as applicable) are met, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.2 – Initial Enrollments Requiring Direct Referral to the Regional Office (Including Federally Qualified Health Centers) (Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your Medicare enrollment application and has forwarded it to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). After the CMS Regional Office determines whether all conditions of (insert "participation" or “coverage,” as applicable) are met, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of Regional Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.3 – Changes of Information

(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

This letter shall be used for change requests that require a referral to the State and/or Regional Office (RO) (as applicable). See the appropriate sections of this chapter for information on changes that mandate referral to the State and/or RO.

15.24.6.3.1 – Changes of Information Requiring Referral to the State

(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your request to update your Medicare enrollment information and has forwarded it to [Name of State Office]. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your request, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.3.2 – Changes of Information Requiring Direct Referral to the Regional Office

(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

(This letter shall be used for change requests that require a referral to the RO but not the State because there is no State involvement with these provider/supplier types (e.g., federally qualified health centers))

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your request to update your Medicare enrollment information and has forwarded it to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your request, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.4 – Potential Changes of Ownership Under the Principles of §489.18

(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

(These letters shall be used for potential changes of ownership under the principles of §489.18.)

15.24.6.4.1 – Potential Changes of Ownership Under the Principles of §489.18 - Referral to the State Required

(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your change of ownership application and has forwarded it to [Name of State Office]. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your application, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.4.2 – Potential Changes of Ownership Under the Principles of §489.18 –Direct Referral to the Regional Office Required (Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your change of ownership application and has forwarded it to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your application, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.7.1 – Model Approval Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

We are pleased to inform you that your [initial Medicare enrollment application]/[revalidated Medicare enrollment application]/[change of information request] is approved. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

To start billing, you must use your NPI on all Medicare claim submissions. Because the PTAN is not considered a Medicare legacy identifier, do not report it as an “other” provider identification number to the National Plan and Provider Enumeration System (NPPES).

Your PTAN has been activated and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system. The IVR allows you to inquire about claims status, beneficiary eligibility and transaction information.

If you plan to file claims electronically, please contact our EDI department at [phone number].

Medicare Enrollment Information

Provider \ Supplier name: [Name]
National Provider Identifier (NPI): [NPI]
Provider Transaction Access Number (PTAN): [PTAN]
Specialty: [Provider specialty]
You are a: [participating]/[non-participating]
Effective date: [Effective date]
Medicare Year-End Cost Report date: [Date]
Changed Information: [List all updates/changes]

Please verify the accuracy of your enrollment information.

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to [42 C.F.R. § 424.516 or 42 C.F.R. § 424.205]. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) [practice location or administrative locations and/or community settings], (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS).

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert contractor's web address].

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.

- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]

[Address]

[City], ST [Zip]

or

[Centers for Medicare & Medicaid Services]

[Provider Enrollment & Oversight Group]

[ATTN: Division of Compliance & Appeals]

[7500 Security Blvd.]

[Mailstop: AR-19-51]

[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

If you have any questions, please contact our office at [phone number] between the hours of (x:00 AM/PM) and (x:00 AM/PM).

Sincerely,

(Name)

(Title)

(Company)

15.24.8 – Denial Letter Guidance

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

- The contractor must submit one or more of 10 Primary Denial Citations as found in x.x.x into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.
- The contractor may submit a Specific Denial Reason, as appropriate. The Specific Denial Reason should state sufficient details so it is clear as to why the provider or supplier is being denied.
- Specific Denial Reasons may contain one or more of the following items:
 - A specific regulatory (CFR) citation.
 - Dates (of actions, suspensions, convictions, receipt of documents, etc.)
 - Pertinent details of action(s)
- National Supplier Clearinghouse (NSC) only language. All denial letters for the NSC shall replace the 1st paragraph of the model denial letter with the following text:

Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR §405.800, 42 CFR §424.57, and 42 CFR §498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):

Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

You may not appeal through this process the merits of any exclusion by another federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the federal agency that took the action.

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR §410.33(g) 1 through 17. For DMEPOS providers and suppliers, the standards are found in 42 CFR §424.57(c) 1 through 30. For MDPP suppliers, the standards are found in 42 CFR §424.205(d).

15.24.8.1 – Model Denial Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx C.F.R. § xxx.(x) [heading]

[Specific reason]

xx C.F.R. § xxx.(x) [heading]

[Specific reason]

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if denied under 42 C.F.R. § 424.530(a)(1))

You may submit a corrective action plan (CAP) in response to the denial of an enrollment application under 42 C.F.R. § 424.530(a)(1). You may also request a reconsideration (described below). If your enrollment application was denied under authorities other than 42 C.F.R. § 424.530(a)(1), you may **only** submit a reconsideration request in response to those denial bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to enroll in the Medicare program. (Optional Coversheet sentence: [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed to the address below or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

Please note that CAPs may not be appealed further to the Departmental Appeals Board. Further appeal rights do exist for reconsideration requests (described below). CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|------------------|----|--|
| [Name of MAC] | or | [Centers for Medicare & Medicaid Services] |
| [Address] | | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional

Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If denied under 42 C.F.R. § 424.530(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.8.3 – Denial Example #2 – Criteria for Eligible Discipline Not Met

(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

June 7, 2012

Marjorie Gosling, NP
6578 Billings Avenue
Calgary, MI 42897

Reference # (Contractor Control Number or NPI)

Dear Ms. Gosling:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse practitioners.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative

appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Muffy McDowell
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

**15.24.8.4 – Denial Example #3 – Provider Standards Not Met
(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 1, 2012

IDTF Services, Inc.
2498 Blood Draw Way
Eagle Rock, Arizona 98001

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met

Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial

numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated

official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

**15.24.8.5 – Denial Example #4 – Business Type Not Met
(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 5, 2012

Roger Bain, M.S. CCC-SLP
6092 Wisconsin Way
Royal, MN 59034

Reference # (Contractor Control Number or NPI)

Dear Mr. Bain:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners [NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz

Applications Analyst
Medicare Administrative Contractor, Inc.

**15.24.8.6 – Denial Example #5 – Existing or Delinquent
Overpayments**

(Rev.717, Issued: 05-12-17, Effective: 05-15-17, Implementation: 05-15-17)

[Date]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):
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.

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment)

If you believe that you are able to correct the deficiencies and establish your eligibility in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop Code (AR-18-50)
Baltimore, MD 21244

If you believe that this determination is not correct, you may request a

reconsideration before a hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §489.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop Code (AR-18-50)
Baltimore, MD 21244

If you have any questions, please contact our office at (phone number) between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.8.7 – Denial Example #6 – MDPP Supplier Standards Not Met – Ineligible Coach
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

April 1, 2018

MDPP Services, Inc.
2498 Prevention Way
Koloa, Hawaii 96756

Reference # (Contractor Control Number or NPI)

Dear MDPP Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:

42 CFR §424.205(d)(3) - The MDPP supplier must not include on the roster of coaches nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria.

42 CFR §424.205(e)(v)(a) specifies that an individual with a state or federal felony conviction in the previous 10 years of any crime against persons, such as murder, rape, assault, and other similar crimes, would not meet the eligibility criteria to be an MDPP coach.

The following coach included on Section 7 of your Form CMS-20134 or its electronic equivalent meets this ineligibility criteria:

John B. Doe | DOB: June 19, 1991 | NPI: 1234567

Please see attached documentation of the felony conviction.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements and no longer have an ineligible coach on your roster. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional

information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.9 – Revocation Letter Guidance
(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

The contractor:

- Shall submit one or more of the Primary Revocation Reasons as found in section 15.27.2 or the MDPP specific Revocation Reason outlined in 15.27.3.c into the appropriate section of the Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason;
- Shall include sufficient details to support the reason for the provider or supplier's revocation;
- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;
- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[Month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and thereby, establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

| | | |
|--|----|--|
| [Name of MAC] [Address] [City], ST [Zip] | or | [Centers for Medicare & Medicaid Services] [Provider Enrollment & Oversight Group] [ATTN: Division of Compliance & Appeals] [7500 Security Blvd.] [Mailstop: AR-19-51] [Baltimore, MD 21244-1850] |
|--|----|--|

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.

- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]
[Address]
[City], ST [Zip]

or

[Centers for Medicare & Medicaid Services]
[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]

[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address] or [ProviderEnrollmentAppeals@cms.hhs.gov]
Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.9.2 – Model Revocation Letter for National Supplier Clearinghouse (NSC)

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Certified mail number: [number]
Returned receipt requested

Dear [Provider/Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the CMS 855S enrollment application. The 30day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.579(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (A) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you

fail to refund the beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

Right to Submit a Corrective Action Plan (CAP) and Reconsideration Request:

Corrective Action Plan: (Only if revoked under 42 C.F.R. § 424.535(a)(1))

You may submit a corrective action plan (CAP) in response to the revocation of Medicare billing privileges under 42 C.F.R. § 424.535(a)(1). You may also request a reconsideration (described below). If your Medicare billing privileges were revoked under authorities other than 42 C.F.R. § 424.535(a)(1), you may **only** submit a reconsideration request in response to those revocation bases.

The CAP is an opportunity to demonstrate that you have corrected the deficiencies identified above and establish your eligibility to maintain enrollment in the Medicare program. (Optional Coversheet sentence [To facilitate the processing of your CAP, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]) The CAP must:

- Be received in writing within 35 calendar days of the date of this letter and mailed and/or emailed to the address below;
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a CAP on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.
- Provide evidence to demonstrate that you are in compliance with Medicare requirements.

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP)

[Name of MAC]

[Centers for Medicare & Medicaid Services]

[Address]
[City], ST [Zip]

or

[Provider Enrollment & Oversight Group]
[ATTN: Division of Compliance & Appeals]
[7500 Security Blvd.]
[Mailstop: AR-19-51]
[Baltimore, MD 21244-1850]

Or emailed to:

[Insert MAC email address]

Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.]])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed and/or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
 - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
 - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
 - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for

reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.
- (If revoked under 42 C.F.R. § 424.535(a)(2)) Please note that you may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|------------------|----|--|
| [Name of MAC] | or | [Centers for Medicare & Medicaid Services] |
| [Address] | | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [ATTN: Division of Compliance & Appeals] |
| | | [7500 Security Blvd.] |
| | | [Mailstop: AR-19-51] |
| | | [Baltimore, MD 21244-1850] |

Or emailed to:

[Insert MAC email address]

Pursuant to 42 CFR §424.535(c), CMS is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This re-enrollment bar only applies to your ability to submit a new enrollment application to the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.9.3 – Revocation Example #1 – Abuse of Billing
(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

June 16, 2012

Bennie Scholls, D.P.M.
4321 Bunion Road
Excalibur WA 98234

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear Dr. Scholls:

Your Medicare privileges are being revoked effective June 16, 2012 for the following reasons:

Revocation reason: 42 CFR §535(a) (8)

Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed and dated by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another

Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

Pursuant to 42 CFR §424.535(c), Medicare Administrative Contractor, Inc. is establishing a re-enrollment bar for a period of Three (3) years. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Joe Nail
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

**15.24.9.4 – Revocation Example #2 – DMEPOS supplier revocation
(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

May 17, 2012

Do We DME, Inc. DBA DME of Anywhere
1500 7th Avenue
Anywhere, PA 99999

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear Do We DME, Inc. DBA DME of Anywhere:

The purpose of this letter is to inform you that pursuant to 42 CFR 405.800, 42 CFR 57(e), and 42 CFR 424.535(a)(5), your Medicare supplier number [98765432101] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

Pursuant to 42 CFR 424.535(c), NSC is establishing a re-enrollment bar for a period of two (2) year from the effective date of the revocation. This enrollment bar applies only to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your supplier type.

We have determined that you are not in compliance with the supplier standards noted below:

CFR 424.57(c) (7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of the NSC attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR 424.535(a)(5).

CFR 424.57(c) (26) must meet the surety bond requirements specified in paragraph (d) of this section (CFR 424.57(d)).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the NSC number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879 (h) of the Social Security Act, you may be liable for Civil Monetary penalties.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state

the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

In addition, if submitting a CMS 855S application after the re-enrollment bar has expired, 42 CFR 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of \$50,000 for each final adverse action imposed. Therefore if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base \$50,000 amount that must be maintained.

The reconsideration request should be sent to:

National Supplier Clearinghouse
P.O. Box 12345
ATTN: Hearings and Appeals
Somewhere, AK 11111-1111

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait two (2) year(s) before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

If you have any questions, please contact our office at (866) 238-9652 between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

Hezekiah Thigpen
Fraud Analyst - Supplier Audit and Compliance Unit
National Supplier Clearinghouse

15.24.9.5 – Revocation Example #3 – MDPP Supplier Use of an Ineligible Coach
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

June 16, 2018

MDPP Services, Inc
2498 Prevention Way

Koloa, HI 96756

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear MDPP Services, INC:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

Revocation reason: 42 CFR §424.535(a)(1) – Not in Compliance with Medicare Requirements

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action. The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510

Anytown, IL 12345

Pursuant to 42 CFR §424.205(h)(v)(B)(2), Medicare Administrative Contractor, Inc. is establishing a re-enrollment bar for a period of Three (3) years. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Joe Nail
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

15.24.10 –Reserved for Future Use

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

15.24.10.1 –CAP Withdrawn Acknowledgement Template

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re:

[Provider/Supplier Name] Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further

administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt
Address] [Call Center
Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be

electronic) [Name of Hearing Officer]
[Position of
Hearing Officer]
[MAC Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name] Attn:
[Signer/Submitter of CAP]
[Address] (Address from which the
CAP was sent) [City], [State] [Zip
Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears
in PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your written withdrawal request in regard to your corrective action plan (CAP) received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a decision regarding your CAP. Therefore, [MAC Name] considers your CAP dated [Month] [DD], [YYYY] to be withdrawn. As a result, a decision will not be issued in response to your CAP.

If you have not yet filed a reconsideration request, please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt
Address] [Call Center
Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be

electronic) [Name of Hearing Officer]

[Position of
Hearing Officer]

[MAC Name]

**15.24.10.2 – - CAP Receipt Acknowledgement Email Template to
Provider/Supplier/Representative**

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier

Name]

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your corrective action plan (CAP) on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to consider during the CAP review you must submit that information prior to a decision being issued.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt
Address] [Call Center
Telephone Number]

Sincerely

[Signature of Hearing Officer] (May
be electronic) [Name of Hearing
Officer]
[Position of Hearing
Officer] [MAC
Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name] Attn:
[Signer/Submitter of CAP]
[Address] (Address from which the
CAP was sent) [City], [State] [Zip
Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears
in PECOS) NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your corrective action plan (CAP) on behalf of
[Provider/Supplier Name]. Please be advised that [MAC Name] has 60 calendar
days to review your CAP and render a decision.

If you have additional information that you would like a hearing officer to
consider during the CAP review you must submit that information prior to a
decision being issued.

Please be advised that failure to timely submit a reconsideration request is

deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt
Address] [Call Center
Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May

be electronic) [Name of Hearing

Officer]

[Position of Hearing

Officer] [MAC

Name]

15.24.10.3 - CAP Decision Email Template to Provider/ Supplier/Representative

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

(Be sure to attach a copy of the final decision[s] in PDF format.)

Dear [Name of the person(s) who submitted the CAP]:

Please see the attached decision regarding your Medicare Provider Enrollment CAP.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal
Receipt Address]
[Call Center

Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May
be electronic) [Name of Hearing
Officer]
[Position of
Hearing Officer]
[MAC Name]

15.24.10.4 – CAP Not Actionable (Moot) Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name] Attn:
[Signer/Submitter of CAP]
[Address] (Address from which the CAP was sent) [City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the CAP is no longer actionable. This issue is moot, and we are unable to render a decision on the

matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.5 – Untimely CAP Dismissal Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/
Firm Name] Attn:
[Signer/Submitter of CAP]
[Address] (Address from which the
CAP was sent) [City], [State] [Zip
Code]

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in

PECOS) NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the CAP received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A CAP must be

received within 35 calendar days of the date of the initial determination letter. Your CAP was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a decision in this matter.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal
Receipt Address] [Call
Center Telephone
Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.10.6 – Improperly Signed CAP Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name] Attn:
[Signer/Submitter of CAP]
[Address](Address from which the CAP was sent) [City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears

in PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement was stated in the initial determination letter, dated [Month] [DD], [YYYY], as well as in Chapter 15 of the Medicare Program Integrity Manual.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for instructions on how to properly file a reconsideration request. If you have already submitted a reconsideration request, you will receive further communication related to that submission. Failure to timely file a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.7 – No CAP Rights Dismissal Model Letter
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/
Firm Name] Attn:
[Signer/Submitter of CAP]
[Address](Address from which the CAP
was sent) [City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears
in PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC
Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your CAP. A provider or supplier may only submit
a CAP if there has been a denial of enrollment in the Medicare program under 42
C.F.R § 424.530(a)(1) or the revocation of Medicare billing privileges under 42
C.F.R. § 424.535(a)(1). Your enrollment was not denied or revoked under one of the
aforementioned authorities. Therefore, a CAP decision cannot be rendered based on
this submission.

Please refer to the initial determination letter, dated [Month] [DD], [YYYY], for
instructions on how to properly file a reconsideration request. If you have already
submitted a reconsideration request, you will receive further communication
related to that submission. Please be advised that failure to timely submit a
reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal
Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.8 – Not Eligible to Submit CAP Dismissal Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/
Firm Name] Attn:
[Signer/Submitter of CAP]
[Address](Address from which the
CAP was sent) [City], [State] [Zip
Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in
PECOS) NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the [corrective action plan (CAP)] received by [MAC
Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [CAP] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights extend only to initial determinations related to the denial or revocation of Medicare billing privileges.

If you have any further questions, please forward your inquiries to [MAC Appeal
Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.9 – CAP Signature Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP] (If submitted on behalf of an organization or group)

[Address] (Address from which the CAP was sent)

[City], [State] [Zip Code]

Re: Corrective Action Plan Submission

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the CAP]:

We are in receipt of your CAP submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as stated in the initial determination letter and in the Medicare Program Integrity Manual, Ch. 15, Section 15.25. [MAC Name] is requesting that you submit a CAP that is properly signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a CAP that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or

supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your CAP submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mailed to the following address:

[MAC Appeal Receipt Address]
[MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.10 – Favorable CAP Model Letter in Response to an Enrollment Denial

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/
Firm Name] Attn:
[Signer/Submitter of CAP]
[Address](Address from which the CAP
was sent) [City], [State] [Zip Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in
PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received on [Month] [DD], [YYYY];

therefore, this CAP is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial

determination. This section should include: A clear explanation of why the denial was overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement. Approval date should be based on the date the provider or supplier came into compliance with all applicable Medicare requirements.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license expired. However, on [Month] [DD], [YYYY] John Smith submitted a copy of his renewed medical license, which was reinstated back to the date of expiration by the Wisconsin Medical Board. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.11 - Favorable CAP Model Letter for Revocation Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name] Attn: [Signer/Submitter of CAP]
[Address](Address from which the CAP was sent) [City], [State] [Zip Code]

Re: Corrective Action Plan Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the

hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance.

If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld or overturned in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory basis to support the revocation for noncompliance, and an explanation of how the provider or supplier now meets the enrollment compliance criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was suspended. However, as part of her CAP, Jane Doe submitted a revised order from the Wisconsin Medical Board, which reinstated her medical back license back to the date of suspension. As a result, [MAC Name] finds that Jane Doe came into compliance with the applicable Medicare requirements on [Month] [DD], [YYYY]. Therefore, [MAC Name] overturns the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

This decision is a **FAVORABLE DECISION**. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on chapter 15 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this CAP decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.12 – Unfavorable CAP Model Letter in Response to an Enrollment Denial

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/
Firm Name] Attn:
[Signer/Submitter of CAP]
[Address](Address from which the
CAP was sent) [City], [State] [Zip
Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in
PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXXX]

(optional)

Dear [Person(s) who submitted

the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.])The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON:

- 42 C.F.R. § 424.530(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP).

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance under 42 C.F.R. § 424.530(a)(1). If the initial determination was based on any other denial reasons other than 42 C.F.R. § 424.530(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the denial is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support each reason for the denial, and an explanation of how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe's Medicare enrollment application under 42 C.F.R. § 424.530(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP does not correct the deficiencies that led to the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]

[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.10.13 – Unfavorable CAP Model Letter for Revocation Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/
Firm Name] Attn:
[Signer/Submitter of CAP]
[Address](Address from which the
CAP was sent) [City], [State] [Zip
Code]

Re: Corrective Action Plan Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in
PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX]

(optional) Dear [Person(s)]

who submitted the CAP]:

This letter is in response to the corrective action plan (CAP) received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and the CAP was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the CAP is untimely, but good cause has been found to accept the CAP, use the following [This CAP was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCATION REASON:

- 42 C.F.R. § 424.535(a)(1)

OTHER APPLICABLE AUTHORITIES:

- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: (Ex.: CAP, signed by Jane Doe, dated [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the CAP.)

CORRECTIVE ACTION PLAN ANALYSIS:

[A [Provider/Supplier Name] may only submit a corrective action plan for noncompliance.

If the initial determination was based on revocation reasons other than 42 C.F.R. § 424.535(a)(1), this decision will not review those authorities.]

(A CAP is an opportunity to correct the deficiencies identified in the initial determination. This section should include: A clear explanation of why the revocation is being upheld in sufficient detail for the provider or supplier to understand the decision and; if applicable: the nature of the provider or supplier's deficiencies, the regulatory or other policy basis to support compliance and how the provider or supplier now meets the enrollment criteria or requirements. This section shall not reference a CAP decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe's medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that her medical license has been reinstated. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1).)

This decision is an **UNFAVORABLE DECISION**. [MAC name] concludes that the CAP did not correct the deficiencies noted in the implementation of the revocation. As a result, the revocation of your Medicare billing privileges is upheld.

Failure to timely file a reconsideration request is deemed a waiver of all further administrative review. However, if you have submitted a reconsideration request, a separate decision is forthcoming.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]

[Call Center Telephone Number]

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.10.14 – CAP Further Information Required for Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the CAP.]

Subject: Medicare Provider Enrollment CAP re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of CAP] (If submitted on behalf of an organization or group)

[Address] (Address from which the CAP was sent)

[City], [State] [Zip Code]

Re: CAP Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the CAP]:

On [Month] [DD], [YYYY], [MAC Name] issued a CAP decision. As stated in the [Month] [DD], [YYYY] CAP decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC CAP Receipt Address]

[MAC CAP Receipt Email Address]

[MAC CAP Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11 – Reserved for Future Use

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

15.24.11.1 – Reconsideration Request Withdrawn Acknowledgement Template

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re:

[Provider/Supplier Name] Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent) [City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your written withdrawal request in regard to your reconsideration request received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a reconsidered decision, and therefore, [MAC Name] considers your reconsideration request to be withdrawn. As a result, a decision will not be issued in response to your reconsideration request.

Please be advised that failure to timely submit a reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.11.2 – Reconsideration Request Receipt Acknowledgement
Template to Provider/Supplier/Representative
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

Email Template

To: [Email address provided by the person who submitted the reconsideration request]

Subject: Medicare Provider Enrollment Reconsideration Request re:
[Provider/Supplier Name]

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address] [Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic) [Name of Hearing Officer]
[Position of Hearing Officer] [MAC Name]

Hard-Copy Letter Template

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

We are in receipt of your reconsideration request on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has 90 calendar days to review your reconsideration request and render a decision.

If you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, you must submit that information to the hearing office before a decision is rendered. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an ALJ specifically allows you to do so under 42 C.F.R. §498.56(e).

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.11.3 – Reconsideration Request Decision Email Template to
Provider/Supplier/Representative**

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration Request]

Subject: Medicare Provider Enrollment [Reconsideration Request] re:
[Provider/Supplier Name]

(Be sure to attach a copy of the final decision[s] in PDF format.)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

Please see the attached decision regarding your Medicare
Provider Enrollment Reconsideration Request.

If you have any further questions, please forward your inquiries to [MAC Appeal
Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]

(May be electronic)

[Name of Hearing Officer]
[Position of Hearing

Officer] [MAC Name]

15.24.11.4 – Reconsideration Request Not Actionable (Moot) Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address] (Address from which the Reconsideration Request was sent) [City], [State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name] based on the initial determination letter, dated [Month] [DD], [YYYY].

In correspondence dated [Month] [DD], [YYYY], the initial determination letter, dated [Month] [DD], [YYYY] informing you of the [denial of your Medicare enrollment application or revocation of your Medicare billing privileges] was [insert description] (describe action taken in regards to the initial determination, i.e. rescission of the denial or revocation). For your convenience, a copy of the initial determination is included. Therefore, the issue set forth in the reconsideration request is no longer actionable. This issue is moot, and we are unable to render a decision on the matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely

[Signature of Hearing Officer]

(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.5 – Untimely Reconsideration Request Dismissal Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address] (Address from which the reconsideration request was sent) [City], [State]
[Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXXX] (optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the initial determination letter dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your reconsideration request as it was not timely submitted. The initial determination letter was dated [Month] [DD], [YYYY]. A reconsideration request must be received within 65 calendar days of the date of the initial determination letter. Your reconsideration request was not received by [MAC Name] until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You have failed to show good cause for your late request. Therefore, [MAC Name] is unable to render a decision in this matter.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.6 – Improperly Signed Reconsideration Request Dismissal Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]
[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the reconsideration request was sent) [City], [State]
[Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the reconsideration request]:

This letter is in response to the reconsideration request received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination letter.

[MAC Name] is unable to accept your reconsideration request as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment record, the individual provider or supplier, or a properly appointed representative. The signature requirement is stated in the [Month] [DD], [YYYY] initial determination letter, as well as in Chapter 15 of the Medicare Program Integrity Manual.

Please be advised that failure to timely submit a proper reconsideration request is deemed a waiver of all further administrative review.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,
[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.11.7 – Not Eligible to Submit Reconsideration Request
Dismissal Model Letter**

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the [reconsideration request] received by [MAC Name], based on the [Month] [DD], [YYYY] initial determination.

[MAC Name] is unable to accept your [reconsideration request] submission because the action taken in regards to your Medicare enrollment is not an initial determination subject to administrative review. More specifically, an initial determination has not been made as described in 42 C.F.R. § 498.3(b). Under 42 C.F.R. § 498.5(l), appeal rights related to provider enrollment extend only from initial determinations.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.8 – Reconsideration Request Signature Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request] (If submitted on behalf of an organization or group)

[Address] (Address from which the Reconsideration Request was sent)

[City], [State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

We are in receipt of your reconsideration submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) [Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 15, Section 15.25. [MAC Name] is requesting that you submit a reconsideration request that is properly signed by the individual provider, supplier, the authorized or delegated official, or a representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a statement by the attorney, use the following.) [Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

(If the submission is missing a signed written notice from the provider/supplier authorizing the representative to act on his/her/its behalf, use the following.) [Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your reconsideration submission may be dismissed.]

Your submission should be sent to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[MAC Fax number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.9 – Favorable Reconsideration Request Model Letter in Response to an Enrollment Denial

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-14)
- 42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], a disciplinary hearing was held regarding the medical license of Jane Doe. However, on [Month] [DD], [YYYY], the Wisconsin Medical Board declined to take disciplinary action against Jane Doe’s medical license. As a result, [MAC Name] overturns the denial of Jane Doe’s Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).

This decision is a FAVORABLE DECISION. To effectuate this decision, [MAC name] will continue processing the enrollment application.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;

- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.10 – Favorable Reconsideration Request Model Letter in Response to a Reactivation Effective Date Determination (Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] related to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been

granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], requesting additional informed needed to process the revalidation application to completion for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit shall include the date, if provided, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision

without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex.: On [Month] [DD], [YYYY], John Smith’s revalidation application was approved with a gap in his billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. However, as indicated above, [MAC Name] has determined that the reactivation effective should be [Month] [DD], [YYYY]. As a result of the change in the reactivation effective date, the gap in John Smith’s Medicare billing privileges has been eliminated.)

This decision is a FAVORABLE DECISION. To effectuate this decision, [MAC name] [will modify/has modified] the reactivation effective date for [Provider/Supplier Name].

You must resubmit any claims that were denied or not previously submitted due to the former gap in your Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to

have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File.

Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]

[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]

(May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.11.11 – Favorable Reconsideration Request Model Letter in Response to an Effective Date of Participation Determination (Non-Revalidation)

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a determination of the effective date of participation in the Medicare program. The initial determination letter was dated [Month] [DD], [YYYY] and the reconsideration request was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this reconsideration request is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated

[Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the determination of the effective date.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial enrollment application, which was subsequently rejected for failure to timely respond to a development request for additional information/documentation. As part of his reconsideration request, John Smith submitted an email receipt showing that he timely responded to the development request. As a result, [MAC Name] will modify John Smith's Medicare effective date to [Month] [DD], [YYYY].)

This decision is a FAVORABLE DECISION. To effectuate this decision, [MAC name] [will modify/has modified] the enrollment effective date to [Month] [DD], [YYYY].

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of

the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the

party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.12 – Favorable Reconsideration Request Model Letter for Revocation Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the

Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCAION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-21)
- 42 C.F.R. § 424.535(a)(revocation reason 1-21)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)

- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has reviewed and/or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1- 21).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the provider or supplier arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. However, on [Month] [DD] [YYYY], the Wisconsin medical board issued an order reversing the license suspension back to its implementation date based on the outcome of a hearing. As a result, [MAC Name] is overturning the revocation of Jane Doe's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(1).

This decision is a FAVORABLE DECISION. To effectuate this decision, [MAC name] [will reinstate/has reinstated] your Medicare billing privileges, effective [Month] [DD], [YYYY].

(The reinstatement date is based on chapter 15 of the MPIM and the date of the provider's or supplier's revocation or the date the provider's or supplier's license was reinstated if the revocation involves a licensure issue.)

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this reconsideration decision. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this decision letter.)

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.11.13 – Unfavorable Reconsideration Request Model Letter
in Response to an Enrollment Denial
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Reconsideration Request]
[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an enrollment denial. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DENIAL REASON(S):

- 42 C.F.R. § 424.530(a)(denial reason 1-14)
- 42 C.F.R. § 424.530(a)(denial reason 1-14)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)
(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the reconsideration request.]

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining denial reason(s) 42 C.F.R. § 424.530(a)(denial reason 1-14).)

(If the CAP resolves the denial in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(Ex: On [Month] [DD], [YYYY], Jane Doe's medical license was temporarily suspended by the Wisconsin medical board based on allegations of malpractice. Jane Doe did not submit any documentation to demonstrate that her medical license was not suspended. In addition, [MAC Name] has confirmed that Jane Doe's medical license remains suspended. As a result, [MAC Name] upholds the denial of Jane Doe's Medicare enrollment application as it relates to 42 C.F.R. § 424.530(a)(1).)

This decision is an UNFAVORABLE DECISION. [MAC name] concludes that there was no error made in the denial of your Medicare enrollment. As a result, the denial of your Medicare enrollment is upheld.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the "Register New Account" form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and

- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.11.14 – Unfavorable Reconsideration Request Model Letter
in Response to a Reactivation Effective Date Determination
(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent) [City],

[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] in response to a reactivation effective date determination. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d) (Other effective date regulations may be included)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. § 424.540 (Other applicable regulations for MPIM sections may be included)
- (Ex: Medicare Program Integrity Manual (MPIM) chapter 15, section 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified by John Smith on [Month] [DD], [YYYY].)
- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been

reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith’s Medicare enrollment was deactivated for failing to timely respond to a revalidation request. On [Month] [DD], [YYYY], John Smith submitted a revalidation application, which was processed and approved. Per the MPIM, Ch. 15, Section 15.29, John Smith’s Medicare enrollment was reactivated, but with a gap in his Medicare billing privileges from [Month] [DD], [YYYY] to [Month] [DD], [YYYY]. John Smith’s reconsideration request did not demonstrate an error in the determination of his reactivation effective date.)

This decision is an UNFAVORABLE DECISION. [MAC name] concludes that no error was made in the determination of a reactivation effective date resulting in a gap in your Medicare billing privileges. As a result, your reactivation effective date will remain [Month] [DD] [YYYY].

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.

- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**15.24.11.15 – Unfavorable Reconsideration Request Model Letter
in Response to an Effective Date of Participation Determination
(Non-Revalidation)**

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent) [City],

[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:
[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on an effective date of enrollment determination. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted, but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

EFFECTIVE DATE REGULATION(S):

- 42 C.F.R. § 424.520(a-d)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: CMS-855I Medicare enrollment application, signed and certified)

by John Smith on [Month] [DD], [YYYY].)

- Exhibit 2: (Ex: Copy of an email chain between John Smith and Jane Doe, dated [Month] [DD], [YYYY], submitting the requested development documentation for John Smith to Jane Doe.)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], John Smith submitted an initial Medicare enrollment application. On [Month] [DD], [YYYY], [MAC Name] sent a development request to John Smith for additional documentation/information to continue processing his enrollment application. However, John Smith did not submit the requested documentation within 30 days. As a result, [MAC Name] properly rejected John Smith's Medicare enrollment application received on [Month] [DD] [YYYY]. On [Month] [DD] [YYYY], John Smith submitted another Medicare enrollment application, which was processed and subsequently approved with an effective date of [Month] [DD], [YYYY] in accordance with 42 C.F.R. § 424.520.

This decision is an UNFAVORABLE DECISION. [MAC name] concludes that no error was made in the determination of your effective date of participation in the

Medicare program. As a result, the effective date of participation will remain the same.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and

- Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service.
- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal

rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer]
(May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.16 – Unfavorable Reconsideration Request Model Letter for Revocation Determination

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration Request]

[Address](Address from which the Reconsideration Request was sent) [City],
[State] [Zip Code]

Re: Reconsideration Request Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS) NPI:

[XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the Reconsideration Request]:

This letter is in response to the reconsideration request received by [MAC Name] based on a revocation of Medicare billing privileges. The initial determination letter was dated [Month] [DD], [YYYY] and was received by [MAC Name] on [Month] [DD], [YYYY]; therefore, this appeal is considered timely. (if the reconsideration request is untimely, but good cause has been found to accept the reconsideration request, use the following [This reconsideration request was not timely submitted,

but a good cause waiver has been granted.]) The following decision is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

REVOCACTION REASON(S):

- 42 C.F.R. § 424.535(a)(revocation reason 1-21)
- 42 C.F.R. § 424.535(a)(revocation reason 1-21)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- (Ex: Medicare Program Integrity Manual chapter 15.XX)

EXHIBITS:

- Exhibit 1: (Ex.: Reconsideration request, signed by Jane Doe, dated [Month] [DD] [YYYY].)
- Exhibit 2: (Ex: Copy of a medical license for Jane Doe from the Wisconsin Medical Board, effective [Month] [DD], [YYYY].)

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include all other documentation not submitted by the provider that the hearing officer reviewed in making the decision, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the decision has been made in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the reconsideration request.)

RECONSIDERATION ANALYSIS:

(The hearing officer needs to check to determine if a CAP was also submitted and approved for this provider or supplier. If so, the reconsideration decision should only address the remaining authorities and use the following sentence, “[MAC Name] has denied or approved the CAP submitted on [Month] [DD], [YYYY] in a decision dated [Month] [DD], [YYYY]. Therefore, this decision will only address the remaining revocation reason(s) 42 C.F.R. § 424.535(a)(revocation reason 1-21).)

(If the CAP resolves the revocation in its entirety, the applicable moot model letter should be issued in response to the reconsideration request instead of this decision template.)

(A reconsideration request reviews whether or not an error was made at the time the initial determination was implemented. This section should summarize the statements made by the provider or supplier in its reconsideration request. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations (MPIM). This section shall not reference a reconsideration decision without explaining how and why you came to that decision.)

DECISION:

(A short conclusory restatement.)

(On [Month] [DD], [YYYY], Jane Doe’s medical license was suspended by the Wisconsin Medical Board. Jane Doe has not submitted evidence to demonstrate that the suspension of her medical license was rescinded. In addition, [MAC Name] has confirmed that Jane Doe’s medical license remains suspended. As a result, [MAC Name] upholds the revocation of Jane Doe’s Medicare enrollment application under 42 C.F.R. § 424.535(a)(1).)

This decision is an UNFAVORABLE DECISION. [MAC name] concludes that there was no error made in the implementation of a revocation. As a result, the revocation of your Medicare billing privileges is upheld.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE (ALJ):

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request ALJ review for the reconsideration portion of this decision letter. To request ALJ review, you must file your appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision.

How to file a hearing request

You can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, you first need to register a new account by:

1. Clicking Register on the DAB E-File home page;
2. Entering the information requested on the “Register New Account” form; and
3. Clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on

your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, you may file your appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

All documents must be submitted in PDF form.

What you must include in a hearing request for ALJ review

At minimum, the Civil Remedies Division (CRD) requires a party to file the following:

- A signed request for hearing that:
 - Identifies the specific issues and the findings of fact and conclusions of law with which the party disagrees; and
 - Specifies the basis for contending that the findings and conclusions are incorrect;
- The underlying notice letter from CMS that sets forth the action taken and the party's appeal rights.

In addition, the following identifying information is required with all ALJ hearing requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

The procedures for ALJ review can be found at Title 42 of the Code of Federal Regulations, sections 498.40 – 498.79.

Guidelines for Using DAB E-file

- Any document, including a request for hearing, will be deemed to have been filed on a given day if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day.
- A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the ALJ, via DAB E-File.

Correspondingly, CMS will also be deemed to have consented to electronic service.

- Parties are responsible for ensuring that DAB E-file email notifications do not go to their spam folders and that any spam filtering software they may have does not restrict their ability to receive emails from the system.

More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E- File Procedures link on the File New Appeal Screen for CRD appeals.

If you are unable to use DAB E-file

Parties are required to use DAB E-file unless they receive a waiver. If you cannot file your appeal electronically, you may mail your hearing request, along with a request for waiver of the electronic filing requirement and an explanation of why you cannot use DAB E-file, to: Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, Mail Stop 6132, Attn: CMS Enrollment Appeal, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, D.C. 20201.

Appeal rights can be found 42 C.F.R. part 498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities meet the requirements for enrollment in the Medicare program.

If you have any further questions, please forward your inquiries to [MAC Appeal Receipt Email Address] or mail it to the following address:

[MAC Appeal Receipt Address]
[Call Center Telephone Number]

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.24.11.17 – Reconsideration Further Information Required for Development Model Letter

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the Reconsideration.]

Subject: Medicare Provider Enrollment Reconsideration re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Reconsideration] (If submitted on behalf of an organization or group)

[Address] (Address from which the Reconsideration was sent)

[City], [State] [Zip Code]

Re: Reconsideration Decision

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the Reconsideration]:

On [Month] [DD], [YYYY], [MAC Name] issued a reconsideration decision. As stated in the [Month] [DD], [YYYY] reconsideration decision letter, the approval of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation within 30 calendar days to:

[MAC Reconsideration Receipt Address]

[MAC Reconsideration Receipt Email Address]

[MAC Reconsideration Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

15.24.12 – Model Identity Theft Prevention Letter

(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,

[Name]

[Title]

[Company]

15.24.13 – Identity Theft Prevention Example

(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

May 16, 2012

Joseph Bock, M.D.

1234 Maple Lane

Anywhere ME 12931

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear Dr. Bock:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

Joseph Bock, M.D.
4321 Oak Drive
Anywhere ME 12910

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at 555-555-1212 between the hours of 8 A.M. and 5 P.M. and refer to your application(s) reference number 123456789.

Sincerely,
Boris Battles
Security Analyst
Medicare Administrative Contractor, Inc.

15.24.14 – Model Documentation Request Letter
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Under 42 CFR § 424.516(f)(1), a provider or supplier who furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified

home health services is required to:

- Maintain documentation for 7 years from the date of service; and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.]

Or

[Under 42 CFR § 424.516(f) (2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.]

Or

[Under 42 CFR §424.205(g), an MDPP supplier is required to maintain documentation for 10 years from the date of services and to provide access to that documentation pursuant to a CMS or Medicare contractor request.]

Consistent with [§ 424.516(f) [(x)] or §424.205(g)], please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

(etc.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

[Name of MAC]
[Address]
[City], ST [Zip]

Failure to timely submit this documentation may result in the revocation of your Medicare billing privileges pursuant to 42 CFR § 424.535(a) (10).

[Name]
[Title]
[Company]
[Title]
[Company]

15.24.15 – Model Deactivation Letter

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-2]

[Specific reason for the deactivation of the provider/supplier’s Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[MAC Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[MAC Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [MAC Name] has not received a Medicare enrollment application reporting this change in ownership.)

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name] [Title] [Company]

**15.24.16 – Model Opt-out Letters
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

The MACs shall use the model letters in this section to respond to eligible practitioners' opt-out affidavits, request additional documentation, approve opt out affidavits and acknowledge the cancelation or early termination of an opt-out. The

MACs shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The MACs may issue the Model Opt-out Development Letter via fax, e-mail or mail to the eligible practitioner.

15.24.16.1 – Opt-out Affidavit Development Letter
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

MACs shall use the following letter to request missing information from an eligible practitioner that wishes to opt-out of Medicare. This letter should be sent only one time and include a request for all missing information. The MAC may select the response type, either via mail, fax or email.

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner]:

[Insert MAC] requires the following information to complete the processing of your Medicare opt-out affidavit:

[Specify information needed]

Submit the requested information within 30 calendar days of the postmark date of this letter [to the address listed below, via fax to (###-###-####), or via email to (enter PE analyst's email address here)]. We may reject your opt-out affidavit if you do not furnish the requested information within this timeframe.

[Name of MAC]

[Address]

[City], [ST]

[Zip]

Attach a copy of this letter with your revised opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM.]

Sincerely,

[Name]

[Title]
[Company]

15.24.16.2 – Opt-out Rejection Letter
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

In the event that an eligible practitioner does not respond timely or does not respond with needed information to complete an opt-out affidavit, the MACs shall issue this rejection letter.

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

[Insert MAC] is rejecting your Medicare opt-out affidavit, received on [insert date], for the following reason(s):

[List all reasons for rejection:]

To resubmit your opt-out affidavit include all information needed to process your opt-out request. Additional information on submitting a complete opt-out affidavit can be found at: [enter MAC website address].

Return the completed opt-out affidavit to:

[Name of MAC]
[Address] [City],
[ST] [Zip]

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.3 – Opt-out Return Letters

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

Opt-out affidavits should only be returned for the following reasons:

1. The eligible practitioner requesting to opt-out of Medicare is not appropriately licensed by the state,
2. The practitioner is a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.),
3. The opt-out affidavit is filed with an incorrect MAC, or
4. The eligible practitioner decides not to opt out of Medicare while their opt-out affidavit is still in process, but not yet approved by the MAC.

MACs shall issue the specific letter for the return reason.

15.24.16.3.1 – Opt-out Return Letter – Unlicensed Eligible Practitioner

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], as you are not licensed by the state for the specialty type you indicated on your opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

15.24.16.3.2 – Opt-out Return Letter – Ineligible Practitioner

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you indicated a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.) of Medicare.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.3.3 – Opt-out Return Letter – Submitted to Incorrect MAC

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because your opt-out affidavit was filed with an incorrect Medicare Administrative Contractor for the state that you are located in. Your affidavit should be resubmitted to the appropriate contractor for processing.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.3.4 – Opt-out Return Letter – Withdraw of Affidavit During Processing

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.4 – Opt-out Affidavit Approval Letters

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The MACs shall issue an Opt-out Affidavit Approval ~~this~~ model letter when approving an opt-out affidavit and PECOS has been updated with the affidavit information. The approval letter shall be issued for the following reasons:

1. Approved Opt-Out, Eligible Practitioner May Order & Refer
2. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (OIG Exclusion)
3. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Ineligible Specialty)
4. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Did Not Elect to Order & Refer)

5. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

The Opt-out approval letter shall include:

- The eligible practitioner’s personal information:
 - Name,
 - Address,
 - NPI,
 - Specialty, and
 - Eligibility to order and refer.
- The eligible practitioner’s opt-out effective date.
- The date that the eligible practitioner can submit a request to cancel their opt-out affidavit (at least 30 days prior to the end-date of their current opt-out period) ~~and~~
- The date the eligible practitioner can terminate his/her opt-out early (if they are eligible to so, no later than 90 days after the effective date) of the eligible practitioner’s initial 2-year opt-out period.

15.24.16.4.1 – Opt-out Affidavit Approval Letter – Eligible Practitioner Approved to Order & Refer

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|-------------------------------------|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are eligible to Order and Refer |

Effective Date:

[Effective date]

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
 - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for

reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

**15.24.16.4.2 – Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Excluded by the OIG)
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

Eligible Practitioner Name: [Name]
Address of File: [Address, City, State, Zip]
National Provider Identifier (NPI): [NPI]
Specialty: [Specialty]
Ordering and Referring: You are not eligible to Order and Refer*
Effective Date: [Effective date]

* You have been excluded by the OIG (and even if you have or have not obtained a waiver according to 42 CFR §1001.1901(c)), you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.

- If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.4.4 – Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Did Not Elect to Order and Refer)
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries as you did not elect to be and ordering and referring practitioner on your opt-out affidavit.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.

- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
 - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.4.5 – Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|-------------------------------------|--|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [Not Provided] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have not obtained an NPI.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
 - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

15.24.16.5 –Opt-out Renewal Alert Letter

(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

The MACs shall issue the following letter, informing the eligible practitioner that the opt-out is due to be automatically renewed.

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

We are writing to inform you that your opt-out will be automatically renewed for a new 2 year opt-out period, on [Month, DD, YYYY].

To cancel your opt-out in the future, you will need to submit a cancellation request at least 30 days prior to the end of your opt-out period, which is [Month DD, YYYY].

If your intention is to cancel your opt-out, but fail to submit a cancellation notice to us, please see the Appeal Rights section of this letter below.

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the auto-renewal date and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.

- If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

**15.24.16.6 – Opt-out Affidavit Termination Letter
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

If an eligible practitioner timely terminates his/her initial opt-out, the MACs shall acknowledge this action by using this model letter.

Month DD, YYYY

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] completed your request to terminate your Medicare opt-out affidavit.

If you have not previously enrolled with Medicare and want to enroll as a Medicare billing provider or for the sole purpose of ordering and referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
 - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

15.24.16.7 – Opt-out Affidavit Cancel Letter
(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)

If an eligible practitioner timely submits an opt-out cancellation request, the MACs shall acknowledge this action by using this model letter.

Month DD, YYYY

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] completed your request to cancel your Medicare opt-out affidavit.

Your opt-out status will be canceled effective [Month DD, YYYY].

Want to enroll as a Medicare billing provider or for the sole purpose of ordering of referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination.

Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
 - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
 - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]

[Title]

[Company]

15.25 – Review Procedures for Determinations that Affect Participation in the Medicare Program

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Background

This review process of initial determinations applies to all providers and suppliers and ensures that all current and prospective providers and suppliers receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request Administrative Law Judge (ALJ) review of a reconsideration decision within the Civil Remedies Division of the Departmental Appeals Board (CRD DAB). Providers and suppliers may thereafter seek review of the ALJ decision in the Appellate Division of the Departmental Appeals Board (DAB) and may then request judicial review in Federal District Court.

For purposes of this chapter, in accordance with 42 C.F.R. § 498.3, an initial determination includes: (1) the denial of enrollment in the Medicare program; (2) the revocation of a provider's or supplier's Medicare billing privileges; and (3) the effective date of participation in the Medicare program.

Any corrective action plan (CAP) or reconsideration request that purports to challenge an enrollment action other than the initial determinations identified above (including inclusion on the CMS Preclusion List and Opt-Out Status) shall be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt. The Medicare Administrative Contractor (MAC) shall take no action on the provider's or supplier's information on its enrollment record regarding an appeal submission for revocations forwarded to CMS for processing unless otherwise instructed by the Provider Enrollment and Oversight Group (PEOG).

A provider or supplier dissatisfied with the initial determinations referenced above, may challenge the determination. All properly submitted requests shall be reviewed at the enrollment level. As a result, if one letter attempts to challenge the initial determination for a group enrollment in addition to individual practitioner enrollment(s), each enrollment shall receive a separate decision. All submissions

shall be processed in the order in which they are received. All CAPs and/or reconsideration requests will be reviewed by an individual separate and apart from the individual involved in the implementation of the initial determination.

Depending on the regulatory authority under which an initial determination is issued, providers and suppliers may be entitled to submit a CAP and/or a reconsideration request. A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance with all applicable Medicare requirements by correcting the deficiencies (if possible) that led to the initial determination, specifically either the denial of enrollment into the Medicare program under 42 C.F.R. § 424.530(a)(1) or the revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). While CAPs may only be submitted in response to a denial under 42 C.F.R. § 424.530(a)(1) or a revocation under 42 C.F.R. § 424.535(a)(1), all initial determinations allow for the submission of a reconsideration request. A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that led to the initial determination.

Any CAPs and/or reconsideration requests received in response to initial determinations involving the following, either in whole or in part, shall be forwarded to CMS for review within 10 business days of the date of receipt. The CAP and/or reconsideration request shall be sent to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.

- All CAPs and reconsideration requests for certified providers/suppliers (as defined in MPIM, Ch. 15, 15.4);
- CAPs and reconsideration requests for Independent Diagnostic Testing Facilities;
- CAPs and reconsideration requests for Medicare Diabetes Prevention Programs (MDPP);
- CAPs and reconsideration requests for Opioid Therapy Programs (OTPs);
- Reconsideration requests for enrollment denials pursuant, in whole or in part, to 42 C.F.R. § 424.530(a)(2), (3), (6), (11), (12), (13), and (14);
- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), and (21);
- Requests for reversals of denials pursuant to 42 C.F.R. § 424.530(c) and/or revocations pursuant to 42 C.F.R. § 424.535(e);
- Reconsideration requests for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(j);
- Reconsideration requests challenging the addition of years to an existing re-enrollment bar;

- Reconsideration requests challenging whether an individual or entity other than the provider or supplier that is the subject of the second revocation was the actual subject of the first revocation;
- Reconsideration requests challenging an individual or entity being included on the CMS Preclusion List as defined in § 422.2 or § 423.100; and
- Reconsideration requests regarding opt-out status.

If the provider or supplier is denied enrollment or has its Medicare billing privileges revoked, under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), (5) or (9), in conjunction with any denial or revocation reason(s) listed above, those CAPs and/or reconsideration requests should also be forwarded to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt and the determination will be rendered by CMS. If the provider or supplier only submits a CAP for the noncompliance portion of any initial determinations listed above, the CAP must be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov for review within 10 business days of the date of receipt, even if the provider or supplier does not submit a reconsideration request. The MAC shall not process the CAP if it is required to be forwarded to CMS. If the provider or supplier later submits a reconsideration request, the reconsideration request must also be sent to CMS at ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of the date of receipt.

All CAPs and reconsideration requests received by the MACs that are not specifically identified above as being required to be forwarded to CMS for review, shall be processed and a decision rendered by the MACs. However, CMS may exercise its discretion to review any CAP and/or reconsideration request and issue a decision regardless of the basis for the initial determination.

(NOTE: This includes all CAPs and reconsideration requests for DMEPOS suppliers that fit the criteria identified above. In addition, as also indicated above, CAPs may only be submitted for denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocations pursuant to 42 C.F.R. § 424.535(a)(1). However, in the event a CAP is submitted for revocations pursuant, in whole or in part, to 42 C.F.R. § 424.535(a)(2), (3), (4), (7), (8), (10), (12), (13), (14), (17), (18), (19), (20), or (21), the submission should still be forwarded to CMS within 10 business days of the date of receipt to the PEOG Provider Enrollment Appeals inbox at ProviderEnrollmentAppeals@cms.hhs.gov.)

PEOG shall notify the MAC via email when it receives a CAP and/or reconsideration request for a provider or supplier that has not been previously forwarded to PEOG by the MAC. The MAC shall not take any action on a provider or supplier's information on its enrollment record if there is a CAP and/or reconsideration request pending for a revocation action unless otherwise instructed by PEOG. The MAC shall email ProviderEnrollmentAppeals@cms.hhs.gov with any inquiries, questions, or requests.

All documentation related to CAPs and reconsideration requests (including, but not limited to, the decisions) shall be saved in PDF format. The date on the CAP and reconsideration request decisions should be the same date as the date the decision is issued to the provider/supplier/representative.

B. Reopening and Revising CAP and Reconsideration Determinations

Once a CAP and/or reconsideration decision is issued, the MAC shall not reopen and revise a CAP and/or reconsideration decision without PEOG's prior approval, even if the MAC rendered the CAP or reconsideration decision independently. The MAC shall send all requests to reopen and revise a CAP and/or reconsideration decision to ProviderEnrollmentAppeals@cms.hhs.gov and await further instruction before taking any action regarding the CAP and/or reconsideration decision.

C. Requests to the MACs

The MAC shall work with and provide PEOG and the Office of General Counsel (OGC), when applicable, all necessary documentation related to any and all CAPs, reconsideration requests, ALJ appeals, DAB appeals, or requests for judicial review.

The following are examples of information the MAC may be asked to provide. This is not an exhaustive list.

- A copy of the initial determination letter;
- A chronological timeline outlining: (1) the processing of applications; (2) the date they began providing services at the newest assigned location; and (3) if there were development requests;
- The hearing officer's decision as well as the provider or supplier's CAP and/or reconsideration request;
- A complete copy of all application Form CMS-855s, and any supporting documentation submitted with the provider or supplier's application;
- All background information and investigative data the hearing officer used to make their decision. Including any on-site visit reports; the MAC's recommendation for administrative action based on the on-site visit;
- Contact information for the person(s) who signed both the revocation and reconsideration decision letters.

The MAC shall supply PEOG or OGC with all requested documentation within 5 business days of receipt of the request, unless requested sooner.

All requested documentation shall be provided in PDF format (if possible) and saved with a file name that identifies the content of the document.

If a CAP and/or reconsideration decision requires the MAC to take action on a provider's or supplier's enrollment, such as reinstating the provider's or supplier's

enrollment to an active status, the MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date the CAP and/or reconsideration decision is issued unless additional documentation is needed to update the enrollment. If a CAP or reconsideration decision requires the provider or supplier to submit further information before the enrollment can be updated, such as an enrollment application, the MAC shall allow 30 calendar days for the provider or supplier to submit the necessary information. The MAC shall complete all updates to the provider's or supplier's enrollment within 10 business days of the date of receipt of the additional information/documentation. If the provider or supplier does not submit the necessary information within 30 calendar days, the MAC shall contact PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov for further instruction.

D. Timing of CAP and Reconsideration Request Submissions

A provider or supplier who wishes to submit a CAP must file its request in writing within 35 calendar days of the date of the initial determination. A provider or supplier who wishes to submit a reconsideration request must file its request in writing within 65 calendar days of the date of the initial determination. The date on which CMS or the MAC receives the submission is considered to be the date of filing. See section D below for information on calculating timely submissions.

The mailing and email address for all CAPs and reconsideration requests to be rendered by CMS identified in section 15.25(A) is:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
Division of Compliance and Appeals
7500 Security Boulevard
Mailstop AR-19-51
Baltimore, MD 21244-1850
ProviderEnrollmentAppeals@cms.hhs.gov

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review, and may result in the dismissal of any untimely submitted reconsideration request. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to circumstances outside of the provider's or supplier's control such as the following:

- 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

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

If a reconsideration request is not timely filed, as required in 42 C.F.R. § 498.22, CMS will make a determination as to whether good cause exists. If a MAC receives an untimely CAP and/or reconsideration request that it believes is entitled to a good cause exception related to untimeliness, the hearing officer must request approval from PEOG by emailing ProviderEnrollmentAppeals@cms.hhs.gov with an explanation as to why good cause is believed to exist before making a finding of good cause or taking any other action regarding the CAP and/or reconsideration request. The MAC shall not take action on the CAP and/or reconsideration request until it receives a response from CMS regarding the good cause exception request.

E. Time Calculations

Per 42 C.F.R. § 498.22(b)(3), the date of receipt of an initial determination is presumed to be 5 calendar days after the date on the initial determination notice unless there is a showing that it was, in fact, received earlier or later.

A CAP must be received by the MAC or CMS within 35 calendar days of the date of the initial determination. A reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. If the 35th day (for a CAP) or 65th day (for a reconsideration request), falls on a weekend, or Federally recognized holiday, the CAP and/or reconsideration request shall be considered timely filed if received on the next business day. In the case of an email submission of a CAP and/or reconsideration request, the filing date is presumed to be the date of receipt of the email. Consider the following example:

An initial determination letter is dated April 1. The provider is presumed to have received the initial determination on April 6. The provider submits a CAP and/or reconsideration request by mail that is received on June 10, 65 calendar days after April 6. This is considered timely because it is presumed that the provider did not receive the initial determination letter until April 6.

It is the provider or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider or supplier's enrollment information, including its correspondence address. Failure to timely update a correspondence address or other address included in the enrollment record does not constitute an "in fact" showing that an initial determination letter was received after the presumed date of receipt.

F. Signatures

A CAP and/or reconsideration request must be submitted in the form of a letter that is signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative, as defined in 42 C.F.R. § 498.10. If the

representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic.

Authorized or delegated officials for groups cannot sign and submit a CAP and/or reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

(NOTE: The provider or supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "representative" for purposes of signing a reconsideration request without the requisite appointment statement and signature by the individual provider or supplier.)

If the CAP and/or reconsideration request is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the MAC shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the CAP and/or reconsideration request. The MAC shall allow 15 calendar days from the date of the development request letter for the CAP and/or reconsideration request submitter to respond to the development request.

If the CAP and/or reconsideration request submission is not appropriately signed and no response is timely received to the development request (if applicable), the MAC shall dismiss the CAP and/or reconsideration request using the applicable model dismissal letter.

G. Representative for CAP and/or Reconsideration Request

Per 42 C.F.R. § 498.10, a provider or supplier may appoint as its representative any individual that is not disqualified or suspended from acting as a representative in proceedings before the Secretary of the Department of Health and Human Services or otherwise prohibited by law to engage in the appeals process. If this individual is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative. If the representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with CMS or the MAC. Once a representative has been properly appointed, the representative may sign and/or submit a CAP, reconsideration request, request for reversal, or a request for good cause exception on behalf of the provider or supplier.

H. Submission of Enrollment Application while a CAP and/or Reconsideration

Request is Pending/Submission Timeframe has not Expired

If a provider or supplier's enrollment application is denied, the provider or supplier must wait until the time period in which to submit a CAP and/or reconsideration request has ended before submitting a new enrollment application, change of information, or provides any additional information to update their enrollment record. If the MAC receives an enrollment application, change of information, or additional information to update a provider's or supplier's enrollment record prior to the conclusion of the time period in which to submit a CAP and/or reconsideration request, the MAC shall return the application unless the application is received as part of the provider's or supplier's CAP and/or reconsideration request submission. The MAC shall not modify the enrollment record of a provider or supplier that currently has a pending CAP and/or reconsideration request for revocations or is still within the submission time period for denials unless instructed by CMS to do so. Any applications received while the provider or supplier is in a revoked status should be returned to the provider or supplier and not processed pursuant to 15.8.1.

15.25.1 - Corrective Action Plans (CAPs)

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Background

A CAP is a plan that allows a provider or supplier an opportunity to demonstrate compliance by correcting the deficiencies (if possible) that led to the initial determination. CAPs may only be submitted in response to enrollment denials pursuant to 42 C.F.R. § 424.530(a)(1) and revocation of Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

B. Requirements for CAP Submission

CAP submission:

- (1) Must contain, at a minimum, verifiable evidence that the provider or supplier is in compliance with all applicable Medicare requirements;
- (2) Must be received within 35 calendar days from the date of the initial determination (see section 15.25(D) for clarification on timing). The contractor shall accept a CAP via hard-copy mail, email, and/or fax;
- (3) Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;

- (4) Should include all documentation and information the provider or supplier would like to be considered in reviewing the CAP.
- (5) For denials, the denial must be based on 42 C.F.R. § 424.530(a)(1);
- a. For denials based on multiple grounds of which one is § 424.530(a)(1), the CAP may only be accepted with respect to § 424.530(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgement email or letter sent to the provider or supplier using the model acknowledgement letter (If multiple grounds are involved of which one is § 424.530(a)(1), the MAC shall:
 - i. Only consider the portion of the CAP pertaining to § 424.530(a)(1). The other denial bases may only be reviewed as a reconsideration.
- (6) For revocations, the revocation must be based on 42 C.F.R. § 424.535(a)(1);
- a. Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted.
 - i. For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to § 424.535(a)(1), but not with respect to the other grounds. If the provider or supplier submits a CAP that does not comply with this paragraph, the MAC shall address this in the acknowledgment email or letter sent to the provider or supplier using the model acknowledgment letter. (If multiple grounds are involved of which one is § 424.535(a)(1), the MAC shall:
 - 1. Only consider the portion of the CAP pertaining to § 424.535(a)(1). The other revocation bases may only be reviewed as a reconsideration.

C. Receipt Acknowledgment of CAP

If the MAC receives an acceptable CAP for a provider or supplier, the MAC shall use the model acknowledgment letter to email (if a valid email address is available) and send a hard-copy letter to the address included on the CAP submission letter or if no address is listed on the CAP submission letter, then the return address on the envelope from which the CAP was submitted within 14 calendar days of the date of receipt of the CAP, informing the provider, supplier, or its representative that a CAP decision will be rendered within 60 calendar days of the date of receipt of the CAP. If no address is listed in the CAP, then an acknowledgment letter should be sent to

the correspondence address on the provider's or supplier's enrollment record.

If the provider's or supplier's CAP cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative), or any other reason, the MAC shall **not** send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall dismiss the CAP using the applicable model dismissal letter.

D. Dismissing a CAP

A CAP shall be dismissed when the provider or supplier does not have the right to submit a CAP for the initial determination, or when the provider or supplier submitted the CAP improperly or untimely (see 15.25.1(B)). As a result, the CAP shall not be reviewed. The MAC shall use the model dismissal letter when dismissing a CAP. All unacceptable CAPs shall be dismissed as soon as possible.

If a provider or supplier concurrently submits a CAP and reconsideration request, but the initial determination being appealed does not afford CAP rights or the CAP submission is untimely, the MAC shall dismiss the CAP using the No CAP Rights Dismissal Model Letter or Untimely CAP Dismissal Model Letter and review the reconsideration request in accordance with the instruction in 15.25.2.

E. CAP Analysis

The MAC shall only review the CAP as it relates to denial of enrollment pursuant to 42 C.F.R. § 424.530(a)(1) or a revocation of billing privileges pursuant to § 424.535(a)(1). The MAC must determine whether or not the information and documentation submitted with the CAP establishes that the provider or supplier has demonstrated compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination. If the MAC finds that the CAP corrects the deficiency that led to the initial determination, then the MAC shall overturn the initial determination as it relates to the denial reasons under 42 C.F.R. § 424.530(a)(1) or revocation under 42 C.F.R. § 424.535(a)(1). If the denial of enrollment is overturned completely, the MAC shall continue processing the previously denied enrollment application in accordance with standard processing procedures. If the revocation is overturned completely, the MAC shall reinstate the provider's or supplier's enrollment to an approved status based on the date the provider or supplier came into compliance. Consider the following example:

Example 1: A provider or supplier is denied enrollment under 42 C.F.R. § 424.530(a)(1) or revoked under 42 C.F.R. § 424.535(a)(1) because its required license has been suspended. The provider timely submits a CAP in which it provides evidence that its licensure has been reinstated and is currently active. After confirming the status of current licensure, the MAC should render a favorable CAP decision because the provider or supplier has corrected the licensure issue that led to enrollment denial or revocation.

If the provider or supplier submitted a CAP for reasons in addition to 42 C.F.R. § 424.535(a)(1), the MAC shall include in the decision letter that the CAP was reviewed only in regards to the 42 C.F.R. § 424.535(a)(1) basis.

If the provider or supplier does not submit information that establishes compliance with all applicable Medicare rules and requirements by correcting the deficiency that led to the initial determination, the MAC need not contact the provider or supplier for the missing information or documentation. The MAC shall instead deny the CAP. Under 42 C.F.R. § 405.809(a)(2), with respect to the revocation basis, the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.

F. Processing and Approval of CAPs

The time to submit a reconsideration request continues to run even though the MAC has received a CAP and is reviewing the CAP. Therefore, the time period in which to submit a reconsideration request does not stop once a CAP is received and while the CAP is being reviewed. The provider or supplier must submit a reconsideration request within 65 days of the date of the initial determination, even if a CAP is timely submitted and accepted.

The hearing officer shall issue a written decision within 60 calendar days of the date of receipt of the accepted CAP. The hearing officer shall email and mail a hard copy of the CAP decision to the provider or supplier or the individual that submitted the CAP, unless an email address is unavailable or the email is returned, then only a hard copy letter shall be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the reconsideration request. The MAC should also send the CAP decision letter via fax if a valid fax number is available.

If the MAC approves a CAP, it shall notify the provider or supplier by issuing a favorable decision letter following the applicable model CAP letter. The MAC shall continue processing the enrollment application under standard processing timelines or restore billing privileges (as applicable) within 10 business days of the date of the CAP decision or the date of receipt of additional documentation, if needed.

For denials – and unless stated otherwise in another CMS directive or instruction – the effective date is the later of either the date of the filing of the enrollment application or the date on which services were first rendered. Consider the following examples:

- 1.* Denials - A physician's initial enrollment application is denied on March 1, 2018. The physician submits a CAP showing that, as of March 20th, the physician was in compliance with all Medicare requirements. If the MAC or CMS approves the CAP, the effective date of for the physician's Medicare

billing privileges should be March 20th, as that is the day on which the physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with all Medicare requirements until March 20.

2. Revocations – A physician’s medical license is suspended on June 1st. The physician’s Medicare enrollment is revoked under 42 C.F.R. § 424.535(a)(1) on June 15th. The physician then submits a CAP showing that, as of July 1st, the physician is currently licensed. If the MAC or CMS approves the CAP, the effective date for reactivation of the physician’s Medicare billing privileges should be July 1st as that is the day on which physician came into compliance with all Medicare requirements. The 30-day retrospective billing provision does not be apply in this situation.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any CAP decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their CAP decision letter. The MAC shall not reinstate the provider’s or supplier’s enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the CAP decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

G. Withdrawal of CAP

The provider, supplier, or the individual who submitted the CAP may withdraw the CAP at any time prior to the mailing of the CAP determination. The withdrawal of the CAP must be postmarked prior to the CAP determination date. The request to withdraw the CAP must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a CAP, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the CAP and advising that the request has been dismissed, utilizing the applicable model letter.

H. Concurrent Submission of CAP and Reconsideration Request

If a provider or supplier submits a CAP and a reconsideration request concurrently

in response to any denial of enrollment under 42 C.F.R. § 424.530(a)(1) or any revocation of billing privileges under 42 C.F.R. § 424.535(a)(1), the MAC shall first process and make a determination regarding the CAP, only as it relates to the denial and/or revocation under 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1). If the MAC renders a favorable decision as it relates to 42 C.F.R. § 424.530(a)(1) or 42 C.F.R. § 424.535(a)(1), the MAC shall only render a reconsideration decision on the remaining authorities not addressed by the favorable CAP decision. Processing timelines still apply.

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the MAC shall coordinate the review of the CAP and reconsideration request to ensure that the CAP is reviewed and a decision rendered before a reconsideration decision is rendered (if the initial determination is not resolved in its entirety by the CAP decision).

If the CAP is approved and resolves the basis for the initial determination in its entirety, the model CAP decision letter shall be sent to the provider or supplier with a statement that the reconsideration request will not be evaluated because the initial determination has been overturned. If the CAP decision does not fully resolve the initial determination or results in a gap in the provider's or supplier's billing privileges, the MAC shall also process the reconsideration request.

If the CAP is denied:

- There are no further appeal rights; therefore, the CAP decision cannot be appealed. As a result, do not include further appeal rights for a CAP only decision.
- The MAC shall notify the provider or supplier of the denial of the CAP via the applicable CAP model letter.
- The provider or supplier may continue with the appeals process if it has filed a reconsideration request or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if properly submitted, shall be processed.

15.25.2 - Reconsideration Requests

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Background

A reconsideration request allows the provider or supplier an opportunity to demonstrate that an error was made in the initial determination at the time the initial determination was implemented. In contrast to a CAP, a reconsideration request does not allow a provider or supplier the opportunity to correct the deficiencies that

led to the initial determination.

B. Requirements for Reconsideration Request Submission

- 1) Must contain, at a minimum, state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement;
- 2) Must be received within 65 calendar days from the date of the initial determination (see section 15.25(D) for clarification on timing). The contractor shall accept a reconsideration request via hard-copy mail, email, and/or fax;
- 3) Must be submitted in the form of a letter that is signed by the individual provider or supplier, the authorized or delegated official that has been reported within your Medicare enrollment record, or a properly appointed representative;
- 4) Should include all documentation and information the provider or supplier would like to be considered in reviewing the reconsideration request;

C. Receipt Acknowledgement of Reconsideration Request

Upon receipt of a properly submitted reconsideration request, the MAC shall send an email (if a valid email address is available) and hard-copy letter, to the individual that submitted the reconsideration request to acknowledge receipt of the reconsideration request using the applicable model acknowledgment letter within 14 calendar days of the date of receipt of the reconsideration request. The MAC shall send a hard-copy letter to the address listed in the reconsideration request submission or the return address listed on the reconsideration request submission envelope if no address is included on the reconsideration request letter. If no address is listed in the reconsideration request or on the envelope, then an acknowledgment letter should be sent to the correspondence address on the provider's or supplier's enrollment record. In the acknowledgment letter/email (if applicable), the MAC shall advise the requesting party that the reconsideration request will be reviewed and a determination will be issued within 90 calendar days from the date of receipt of the reconsideration request. The MAC shall include a copy of the acknowledgment letter and email (if applicable) in the reconsideration file. If the reconsideration should have been submitted to CMS, the MAC shall not send the provider or supplier an acknowledgment email or letter. Instead, the MAC shall forward the appeal to CMS within 10 business days of the date of receipt of the reconsideration request (as specified in 15.25(A)).

If the provider's or supplier's reconsideration request cannot be accepted due to untimeliness, an improper signature (including a failure to respond to development for the required statement or signed declaration from a representative, or any other reason), the MAC shall **not** send the provider or supplier an acknowledgment email

or letter. Instead, the MAC shall dismiss the reconsideration request using the applicable model dismissal letter.

D. Reconsideration Determination

The MAC shall review all documentation in the record relevant to the initial determination and issue a written determination within 90 calendar days of the date of receipt of the accepted reconsideration request.

A proper reconsideration request must be received by the MAC or CMS within 65 calendar days of the date of the initial determination. Refer to section 15.25(D) for receipt date determinations. However, consistent with 42 C.F.R. § 498.24(a), the provider or supplier, may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the reconsideration decision being issued. The hearing officer must determine whether an error was made in the initial determination at the time the initial determination was implemented, based on all of the evidence presented. This includes:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

If the appealing party has additional information that it would like the hearing officer to consider during the reconsideration or, if necessary, an administrative law judge (ALJ) to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an ALJ specifically allows the party to do so under 42 C.F.R. § 498.56(e).

E. Issuance of Reconsideration Determination

The hearing officer shall issue a written decision within 90 calendar days of the date of receipt of the accepted reconsideration request. The hearing officer shall email and mail a hard copy of the reconsideration decision to the provider or supplier or the individual that submitted the reconsideration request, unless an email address is unavailable or the email is returned, then only a hard copy letter should be mailed to the return address on the reconsideration request/envelope or the mailing address on the provider's/supplier's enrollment record if no return address is included on the

reconsideration request. The MAC should also fax the CAP decision letter if a valid fax number is available. The reconsideration letter shall follow the applicable model letter and include:

- The regulatory basis to support each reason for the initial determination;
- A summary of the documentation that the provider or supplier provided, as well as any additional documentation reviewed as part of the reconsideration process;
- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;
- A clear explanation of why the hearing officer is upholding or overturning the initial determination in sufficient detail for the provider or supplier to understand the hearing officer's decision and, if applicable, the nature of the provider's or supplier's deficiencies. This explanation should reference the specific regulations and/or sub-regulations supporting the decision, as well as any documentation reviewed;
- If applicable, an explanation of how the provider or supplier does not meet the Medicare enrollment criteria or requirements;
- Further appeal rights, regardless of whether the decision is favorable or unfavorable, procedures for requesting an ALJ hearing, and the addresses to which the written appeal must be mailed or e-mailed. Further appeal rights shall only be provided for reconsideration decisions. There are no further appeals rights related to CAP decisions; and
- Information the provider or supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); NPI; and a copy of the reconsideration decision).

Example 1: If a provider or supplier submits a reconsideration request in response to a revocation pursuant to 42 C.F.R. § 424.535(a)(5), the MAC shall review the initial determination, the enrollment application preceding the site visit, the site investigation report(s), the reconsideration request and supporting documentation, as well as any other relevant information, to determine if an error was made in the implementation of the initial determination (e.g., if an error was made during the site visit, or the site visit was conducted at the wrong location.) If the MAC finds that an error was made during the site visit, which found the provider or supplier to be non-operational, the MAC shall order an additional site visit. If an additional site visit is ordered, the MAC shall await the findings of the site investigator, via the site visit report, before issuing a reconsideration decision. If the site visit report finds the provider or supplier to be operational then the MAC shall overturn the revocation of

the provider's or supplier's Medicare billing privileges as it relates to 42 C.F.R. § 424.535(a)(5) using the applicable model letter.

If the MAC overturns the initial determination, the MAC shall reinstate the provider's or supplier's billing privileges to an approved status as of the effective date determined in the reconsidered determination or continue processing the enrollment application (as applicable). Unless otherwise instructed by PEOG, the MAC shall only send the favorable reconsideration decision to the provider or supplier, authorized or delegated official, or its representative at the return address included on the reconsideration request. The reconsideration decision is sufficient for providing notice to the provider or supplier of the enrollment action being taken. All enrollment updates shall be completed within 10 business days of the date the reconsideration decision was issued or the date of receipt of additional documentation, if needed.

For initial enrollments, the effective date of Medicare billing privileges is based on the date the provider or supplier is found to be in compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable retrospective billing provisions. (See section 15.17 of this chapter for more information.) The MAC shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System (PECOS). For DMEPOS suppliers, the effective date is the date awarded by the NSC.

The MAC shall ensure that the applicable CMS Regional Office is notified of the outcome of any reconsideration decision that involves the revocation of Medicare billing privileges for a certified provider or supplier.

If additional information/documentation is needed prior to reinstating the provider or supplier, the MAC shall document these next steps in their reconsideration decision letter. The MAC shall not reinstate the provider's or supplier's enrollment until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the reconsideration decision letter, the MAC shall contact the provider or supplier via the applicable model letter to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the MAC shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

F. Withdrawal of Reconsideration Request

The provider, supplier, or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal of a reconsideration request must be

postmarked prior to the reconsideration decision date. The request to withdraw the reconsideration request must be made in writing, signed, and filed with the MAC or CMS. If the MAC receives a request to withdraw a reconsideration request, it shall send a letter or e-mail to the provider or supplier acknowledging receipt of the request to withdraw the reconsideration request and advising that the request has been dismissed, utilizing the applicable model letter.

G. Requests for Reversal under 42 C.F.R. § 424.530(c)/424.535(e)

Under 42 C.F.R. § 424.530(c)/424.535(e), a provider or supplier may request reversal of a denial of enrollment or revocation of billing privileges if the denial or revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services. The revocation may be reversed, at the discretion of CMS, if the provider or supplier terminates and submits proof that it has terminated its business relationship with the individual against whom the adverse action is imposed within 30 days of the initial determination. Information that may provide sufficient proof includes, but is not limited to, state corporate filings, IRS documentation, sales contracts, termination letters, evidence of unemployment benefits, board governance documents, and payroll records.

If the MAC receives a CAP and/or reconsideration request from a provider or supplier to reverse or rescind a denial or enrollment or revocation due to the termination of the business relationship between the provider or supplier and the individual against whom the adverse action is imposed, the MAC shall not take any action. The MAC shall forward the CAP and/or reconsideration request to ProviderEnrollmentAppeals@cms.hhs.gov within 10 business days of receipt. The MAC shall not take any action pursuant to the request until further instruction is provided by CMS.

H. Not Actionable CAPs and Reconsideration Requests

If the issue in the initial determination is resolved prior to a CAP and/or reconsideration decision being rendered, the basis of the initial determination may become moot and the CAP and/or reconsideration request will be not actionable. The MAC will be notified if an action has been taken that would render a CAP and/or reconsideration request not actionable as CMS would contact the MAC to rescind the revocation or reinstate the provider or supplier's Medicare billing privileges. If the MAC receives such a notification, then the MAC shall review to determine if a CAP and/or reconsideration request has become not actionable. If so, the MAC shall send a hard copy letter should be mailed to the return address on the CAP or reconsideration request, as well as the provider's or supplier's correspondence address using the applicable not actionable model letter. The MAC shall also send an email if a valid email address is available. The MAC may also send via fax if a valid fax number is available. The MAC shall attach a copy of the

letter informing the provider or supplier of the enrollment action which led to the CAP and/or reconsideration request becoming not actionable. If there is a scenario not captured in the not actionable model letter and the MAC believes a CAP and/or reconsideration request has become not actionable, the MAC should email ProviderEnrollmentAppeals@cms.hhs.gov for guidance.

I. Requesting Guidance Related to CAPs and Reconsideration Requests

If the MAC encounters a situation that is not addressed by these instructions, the MAC shall contact the ProviderEnrollmentAppeals@cms.hhs.gov inbox for guidance before taking any action.

15.25.3 – Further Appeal Rights for Reconsidered Determinations (Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Administrative Law Judge (ALJ) Hearing

The CMS or a provider or supplier dissatisfied with a reconsidered determination is entitled to review by an ALJ with the CRD DAB. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. To request final ALJ review, the provider or supplier must file an appeal with the Civil Remedies Division of the Departmental Appeals Board within 60 calendar days after the date of receipt of this decision. A provider or supplier may file an appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.

To file a new appeal using DAB E-File, the provider or supplier must first register a new account by:

- (1) Clicking Register on the DAB E-File home page;
- (2) Entering the information requested on the “Register New Account” form; and
- (3) Clicking Register Account at the bottom of the form. If the provider or supplier has more than one representative, each representative must register separately to use DAB E-File on his/her/its behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative.

Once registered, a provider or supplier may file an appeal by logging in and:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen; and
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

All documents must be submitted in PDF form. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

Pursuant to 42 C.F.R. § 405.809(a)(2), a provider or supplier may not appeal an adverse determination for a CAP, if one was made.

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

Upon receipt of a request for an ALJ hearing, an ALJ at the CRD DAB will issue a letter by certified mail to the supplier, CMS and the OGC acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference, but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The MAC shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter’s request within 5 calendar days of said request.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider’s billing privileges). This may result in PEOG providing specific instructions to the contractor to modify model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns and/or modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider or supplier of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the settlement or ALJ decision no later than 10 business days from the date it received PEOG’s specific instructions.

B. Departmental Appeals Board (DAB) Hearing

CMS or a provider/supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the MAC of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify the model letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The MAC shall complete all steps associated with the DAB decision no later than 10 business days from the date it received PEOG's specific instructions.

C. Judicial Review

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

15.25.4 - External Reporting Requirements for CAPs and Reconsideration Requests

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Monthly

Using the provider enrollment appeals reporting template, the MAC shall complete all columns listed for all appeal submissions (CAPs and reconsideration requests). No column should be left blank.

The response in column A labelled, "Initial Determination Type," should be one of the following:

- **Denial:** CAP or Reconsideration Request that challenges the denial of a Medicare enrollment application pursuant to 42 C.F.R. § 424.530(a)(1)-(11).
- **Revocation:** CAP or Reconsideration Request that challenges the revocation of Medicare billing privileges or provider/supplier number pursuant to 42 C.F.R. § 424.535(a)(1)-(14).
- **Effective Date:** Reconsideration request that challenges an initial determination that establishes an effective date of participation in the Medicare program, including the effective date of reactivation after deactivation.

The response in Column H labelled, “Final Decision Result,” should be one of the following:

1. **Not Actionable:** Appeal is no longer actionable (moot) because the basis for the initial determination has been resolved. (Ex: Fingerprints have received a passed designation, initial determination has been reopened and revised).
2. **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the initial determination. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status, the effective date modified, or application processing has continued.
3. **Unfavorable (to provider/supplier):** MAC upholds the initial determination resulting in the enrollment remaining in a revoked or denied status, or the effective date remaining the same.
4. **Dismissed:** The appeal does not meet the appeal submission requirements. (Ex: incorrect signature, untimely, not appealable, etc.)
5. **Rescinded:** MAC has received instruction from CMS to rescind the initial determination and return the enrollment record to an approved status.
6. **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its appeal (CAP or reconsideration request).

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall cover the prior month’s appeal submissions (e.g., the February report shall cover all January CAPs/reconsideration requests). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

15.26.3 – Additional Home Health Agency (HHA) Review Activities (Rev. 492, Issued: 12-06-13, Effective: 01-07-14, Implementation: 01-07-14)

As stated in section 15.26.2(B)(3) of this chapter, the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this “post-RO review” period.

To confirm that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement, the contractor shall also – during the post-RO review period ensure that each entity and individual listed in sections 2, 5 and 6 of the HHA’s Form CMS-855A application is again reviewed against the Medicare Exclusion Database (MED) and the System for Award Management (SAM) (formerly the General Services Administration (GSA) Access Management System). This activity applies: (1) regardless of whether the HHA is provider-based or freestanding, and (2) only to initial enrollments.

The capitalization and MED/SAM re-reviews described above shall be performed once the RO notifies the contractor via e-mail that the RO’s review is complete. (Per sections 15.4.1.6 and 15.19.2.2 of this chapter, a site visit will be performed after the contractor receives the tie-in/approval notice from the RO but before the contractor conveys Medicare billing privileges to the HHA.) If:

- a. The HHA is still in compliance** (e.g., no owners or managing employees are excluded, capitalization is met):
 1. The contractor shall notify the RO of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.
 2. The RO will: (1) issue a CMS Certification Number (CCN), (2) sign a provider agreement, and (3) send a tie-in notice or approval letter to the contractor. Per section 15.7.7.2.1 of chapter 15, the contractor shall complete its processing of the tie-in notice/approval letter within 45 calendar days of receipt (during which time a site visit will be performed).

- b. The HHA is not in compliance** (e.g., capitalization is not met):
 1. The contractor shall deny the application in accordance with the instructions in this chapter and issue appeal rights. (The denial date shall be the date on which the contractor completed its follow-up capitalization and MED/SAM reviews.)
 2. Notify the RO of the denial via e-mail. (PEOG, not the RO, will handle any CAP or appeal related to the contractor’s denial.)

While, therefore, the process of enrolling certified suppliers and certified providers other than HHAs remains the same (i.e., recommendation is made to State/RO, after which the RO sends tie-in notice to contractor, etc.), the HHA process contains additional steps – specifically, Steps 4 and 5, as outlined below:

1. Contractor processes incoming HHA application and either (1) denies application, or (2) recommends approval to State/RO.
2. State performs survey (if applicable) and makes recommendation to RO.
3. If State recommends approval and RO concurs, RO will – instead of issuing CCN, signing provider agreement and sending tie-in notice/approval letter to contractor at this point, as is done with other certified provider and certified supplier applications – notify contractor that its review is complete.
4. Upon receipt of RO’s notification, contractor will perform capitalization and MED/SAM reviews discussed in sections 15.26.2 and 15.26.3 of this chapter.
5. Once contractor completes its review, it will notify RO as to whether HHA is still in compliance with enrollment requirements.

15.27 – Deactivations and Revocations

(Rev. 354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)

If circumstances warrant, a fee-for-service contractor shall deactivate or revoke a provider or supplier’s Medicare billing privileges under certain circumstances. Deactivation or revocation of Medicare billing privileges will not impact a provider or supplier’s ability to submit claims to non-Medicare payers using their National Provider Identifier.

15.27.1 – Deactivations and Reactivations

(Rev. 474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)

15.27.1.1 – Deactivations

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

A. Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its CMS Provider Enrollment Business Function Lead (PEBFL) - deactivate a provider or supplier's entire enrollment record and Medicare billing privileges when:

- A provider or supplier fails to respond to a revalidation request;

- A provider or supplier fails to respond timely to a revalidation development request, or;
- A provider is enrolled in an approved status without an active reassignment or practice location for 90 days or longer.

The contractor shall not take deactivation actions unless specified in this chapter or other CMS directives. All deactivation notices shall be mailed on the same date listed on the notification letter.

B. Regulations

- Per § 424.540(a)(1), 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;
- Per § 424.540(a)(2), 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; a provider or supplier fails to report a change in ownership or control within 30 calendar days.
- Per § 424.540(a)(3), a 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.

C. Effective Dates

The effective dates of a deactivation are as follows:

1. Non-Billing §424.540(a)(1) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
2. Failure to Report or Furnish Information §424.540(a)(2) and (3), – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.
3. The “36-Month Rule” for HHAs – CMS’ provider enrollment staff will determine the effective date during its review of the case.

D. Rebuttal Rights

A provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal to challenge the deactivation. See 15.27.5 for further instruction.

E. Miscellaneous

1. The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).
2. Prior to deactivating an HHA's billing privileges for any reason (including under the "36-month rule"), the contractor shall refer the matter to its PEBFL for review and approval. The only exception for PEBFL review and approval is deactivations due to failure to comply with a revalidation request.

15.27.1.2 – Reactivations

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

Sections 15.27.1.2.1 through 15.27.2.2 below discuss the requirements for reactivating a provider or supplier's billing privileges.

If the contractor approves a provider or supplier's reactivation application or reactivation certification package (RCP) for a Part B non-certified supplier, the reactivation effective date shall be based on the date the contractor received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the contractor shall issue a new Provider Transaction Access Number (PTAN) unless otherwise stated in this chapter.

Contractors shall grant retrospective billing privileges in accordance with Section 15.17(B) for reactivating providers and suppliers, unless otherwise stated in this chapter. This includes providers that were deactivated for not responding to a revalidation request.

With the exception of HHAs, reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement. Per 42 CFR § 424.540(b)(3)(i), an HHA must undergo a new State survey or obtain accreditation by an approved accreditation organization before its billing privileges can be reactivated. (See section 15.26.3 of this chapter for more information.)

15.27.1.2.1 – Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Background

To reactivate its billing privileges, a provider or supplier deactivated for failing to timely notify the contractor of a change of information (see section 15.27.1.1(A) above) must either:

1. Submit a complete Medicare enrollment application, or
2. Recertify that its enrollment information currently on file with Medicare is correct.

B. Certification Option

1. General Requirements

To utilize option (A)(2) above, the provider or supplier must submit to the contractor (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 or Form CMS-20134 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, and (c) a letter certifying as to the data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).
- (v) Contain the following language:

For Individual Practitioners

"I, _____, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the

terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

A separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record (and the PTANs in that record) the provider or supplier seeks to have reactivated. To illustrate, suppose a supplier has three separate enrollments it wants to reactivate. Each enrollment has its own PECOS enrollment record. Two of the records have one PTAN; the third record contains two PTANs. The supplier must submit three separate PECOS Web printouts, three separate certification statements, and three separate letters. (The letter pertaining to the third enrollment record must list both PTANs.) The certification statement and letter should be attached to the PECOS Web printout to which it pertains – meaning, per our example, that there would be three separate “reactivation certification packages” (RCPs). All RCPs must be submitted via mail. They cannot be faxed or e-mailed.

The provider or supplier cannot utilize the certification option and must submit a complete Form CMS-855 or Form CMS-20134 application if:

- There is any information in the provider or supplier’s PECOS Web enrollment record that is not correct.
- The provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS).
- The provider or supplier cannot otherwise produce a valid RCP.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (B)(1) above. If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).
- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).
- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.
- Reserves the right to request a full Form CMS-855 or Form CMS-20134 application if the contractor has reason to believe that any data in the provider's enrollment record is inaccurate or outdated. However, it shall obtain the approval of its CMS Provider Enrollment Business Function Lead (PEBFL) before making this request.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.1(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider is operational per the site visit, and (5) for HHAs, has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (As stated earlier, though, rejection is appropriate if the provider does not adequately respond to the provider's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

15.27.1.2.2 – Reactivations - Deactivation for Non-Submission of a Claim

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

To reactivate its billing privileges, a provider or supplier deactivated for non-billing must recertify that its enrollment information currently on file with Medicare is correct. This section discusses this requirement.

A. All of Provider's Data in Enrollment Record Is Correct

1. General Requirements

If all of the data in the provider or supplier's enrollment record is correct, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 or Form CMS-20134 certification

statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (c) the claim data described in section 15.27.1.2.3(B) of this chapter, and (d) a letter certifying as to the data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).
- (v) Contain the following language:

For Individual Practitioners

“I, _____, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them.”

For Authorized/Delegated Officials

“I, _____, in my capacity as an authorized or delegated official of (Provider/Supplier), certify on behalf of (Provider/Supplier) that all of the information contained in (Provider/Supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (Provider/Supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

As explained in section 15.27.1.2.2(A), a separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All such “reactivation certification packages” (RCPs) must be submitted via mail. They cannot be faxed or emailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (A)(1) above.

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).

- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).

- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(A), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, and (5) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

B. Some of Provider's Data in Enrollment Record Is Incorrect

1. General Requirements

If any data in the provider or supplier's enrollment record is incorrect, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) applicable hard-copy page(s) of the Form CMS-855 or Form CMS-20134 containing the corrected information (e.g., new section 8 reporting a change to the billing company address), (c) a certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (d) the claim data described in section 15.27.1.2.3(B) of this chapter, and (e) a letter certifying as to the rest of the enrollment data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), NPI, and PTAN(s).
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).
- (v) Contain the following language:

For Individual Practitioners

"I, _____, certify that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted Form CMS-855 pages) - all of the information currently contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted [Form CMS-855 or Form CMS-20134] pages) - all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the

terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

As explained in section 15.27.1.2.2(B), a separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All RCPs must be submitted via mail. They cannot be faxed or emailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (B)(1) above.

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the letter does not identify the information in the enrollment record that is incorrect; (4) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (5) the certification statement or letter is undated; (6) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider’s enrollment record against the MED and the SAM.

- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).

- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

- Process the changed information in accordance with the instructions in this chapter. The entire RCP transaction (including the changed data) shall, however, be processed as a revalidation.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this

section 15.27.1.2.2(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, (5) all of the changed information can be processed to approval, and (6) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its (PEBFL) for guidance.

C. PECOS Web Printout

If the provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS) or cannot otherwise submit a valid RCP, it must submit a complete Form CMS-855 or Form CMS-20134 application in order to reactivate its Medicare billing privileges.

15.27.1.2.3 – Reactivations – Miscellaneous Policies

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Full Enrollment Applications

1. For providers that were deactivated for non-billing, the provider may submit a complete Form CMS-855 or Form CMS-20134 enrollment application in lieu of an RCP. The application may be submitted via paper or PECOS Web.

2. For Form CMS-855 or Form CMS-20134 reactivation applications, the timeliness requirements in sections 15.6.1 et seq., pertaining to initial enrollment applications apply. The contractor shall – unless a CMS instruction directs otherwise - validate all of the information on the application just as it would with an initial application.

3. Unless stated or indicated otherwise:

- The term “Form CMS-855 revalidations” or “Form CMS-20134 revalidations” as used in this chapter 15 only includes Form CMS-855 or Form CMS-20134 revalidation applications. It does not include RCPs.

- The term “revalidation” as used in this chapter 15 includes Form CMS-855 or Form CMS-20134 revalidation applications and RCPs.

B. Claims

For RCP submissions, the provider must also furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. Alternatively, the provider may include in its RCP letter the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.

C. Development

If the initial RCP is incomplete or inadequate and the contractor initiates development procedures, the following principles apply:

- The provider may submit the requested documentation to the contractor via scanned email, fax or mail.
- If there are deficiencies in the RCP letter, the provider must submit (1) a new letter, and (2) a newly-signed and dated certification statement (The certification statement may be submitted by the provider via scanned email, fax or mail). The provider cannot mark-up the previous letter and resubmit it.

15.27.2 – Revocations

(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

A. Revocation Reasons

(Except as described in section 15.27.2(B)(2) below, the contractor shall not issue any revocation or revocation letter without prior approval from CMS' Provider Enrollment & Oversight Group (PEOG).)

When drafting a revocation letter (which, except as described in section 15.27.2(B)(2) below, must be sent to PEOG via the enrollmentescalations@cms.hhs.gov mailbox for approval), the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a)(1)) into the letter. The contractor shall not use provisions from this chapter as the basis for revocation.

1. Revocation Reason 1 (42 CFR §424.535(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) 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. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

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 §424.535(a)(1) may be used 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. (This revocation reason will not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason §424.540(a)(3) in lieu thereof.)
- h. The provider or supplier does not otherwise meet general enrollment requirements.
- i. The provider or supplier has its provider or supplier agreement involuntarily terminated by the CMS regional office (RO) (as evidenced by a tie-in/tie-out notice, CMS-2007, or other notice from the RO/state).

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: 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.

2. Revocation Reason 2 (42 CFR §424.535(a)(2)) – Excluded/Debarred from Federal Program

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 CMS PEOG Business Function Lead (PEOG BFL) immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate Zone Program Integrity Contractor. The COR will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

3. Revocation Reason 3 (42 CFR §424.535(a)(3)) – Felony Conviction

The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR §1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. Offenses include, but are not limited in scope and severity to:

(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.

An 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 Medicare.

4. Revocation Reason 4 (42 CFR §424.535(a)(4)) – False or Misleading Information on Application

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.)

5. Revocation Reason 5 (42 CFR §424.535(a)(5)) - On-Site Review/Other Reliable Evidence that Requirements Not Met

Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

- (i) Is not operational to furnish Medicare-covered items or services; or
- (ii) Otherwise fails to satisfy any Medicare enrollment requirement.

6. Revocation Reason 6 (§424.535(a)(6)) - Hardship Exception Denial and Fee Not Paid

(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.

7. Revocation Reason 7 (42 CFR §424.535(a)(7)) – Misuse of Billing Number

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 §489.18.

8. Revocation Reason 8 (42 CFR §424.535(a)(8)) – Abuse of Billing Privileges

Abuse of billing privileges includes either of the following:

(i) 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. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined in §424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

(NOTE: With respect to (a)(8), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider or supplier has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; (3) accumulate all information needed to make such determinations; and (4) prepare and send all revocation letters.)

9. Revocation Reason 9 (42 CFR §424.535(a)(9)) – Failure to Report Changes

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.

With respect to Revocation Reason 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 pursue a revocation 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 pursue a revocation (e.g., seeking PEOG's approval to revoke).

10. Revocation Reason 10 (42 CFR §424.535(a)(10)) – Non-Compliance with Documentation Requirements

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

11. Revocation Reason 11 (42 CFR §424.535(a)(11)) - Home Health Agency

(HHA) Capitalization

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).

12. Revocation Reason 12 (42 CFR §424.535(a)(12)) – Medicaid Billing Privileges Revoked

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

(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).

13. Revocation Reason 13 (42 CFR §424.535(a)(13)) - DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

14. Revocation Reason 14 (42 CFR §424.535(a)(14)) - CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements.

15. Refer to 15.27.3.c for an additional revocation reason specific to MDPP suppliers alone.

B. Prior PEOG Approval

1. Prior PEOG Approval Necessary

Except as described in section 15.27.2(B)(2) below, the contractor shall obtain approval of both the revocation and the revocation letter from PEOG via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the revocation letter. During its review, PEOG will also determine (1) the extent to which the

revoked provider's or supplier's other locations are affected by the revocation, (2) the geographic application of the reenrollment bar, and (3) the effective date of the revocation. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior PEOG Approval Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- Situation (a), (c), (d), (e), (g), (h), or (i) under Revocation Reason 1 above

§424.535(a)(6) or (a)(11)

C. Effective Date of Revocations

Per 42 CFR §424.535(g), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier.

However, 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.

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 (with prior PEOG approval) 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 discretion to determine whether sufficient "proof" exists.

D. Re-enrollment Bar

1. Background

As stated in 42 CFR §424.535(c), if a provider, supplier, owner, or managing employee has 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. The re-enrollment bar begins 30 days after CMS or its contractor

mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. (Felony convictions, however, always entail a 3-year bar.) Per §424.535(c), the reenrollment bar does not apply if the revocation (1) is based on §424.535(a)(1), and (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.

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: Reenrollment bars apply only to revocations, not to denials. The contractor shall not impose a reenrollment bar following a denial of an application.)

2. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances, and it should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 3 years).

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license; 3 years if billing after loss of license; 3 years for violation of a Medicare policy (using certification statement)
- §424.535(a)(2) (Provider or Supplier Conduct) – 3 years
- §424.535(a)(3) (Felonies) – 3 years
- §424.535(a)(4) (False or Misleading Information) – 3 years
- §424.535(a)(5) (Onsite Review) – 2 years
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(7) (Misuse of Billing Number) – 3 years
- §424.535(a)(8) (Abuse of Billing) – 3 years
- §424.535(a)(9) (Failure to Report) - 1 year if licensure, practice location, revocation; 3 years if felony or exclusion
- §424.535(a)(10) (Failure to Provide CMS Access) – 1 year

- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
- §424.535(a)(12) (Medicaid Termination) – 2 years
- §424.535(a)(13) (Prescribing Authority) – 2 years
- § 424.535(a)(14) (Improper Prescribing Practices) – 3 years

3. Applicability of Bar

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

- John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under §424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.
- Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under §424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.
- John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located, and John Smith is listed as a 75 percent owner.

E. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(h), a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the later of: (1) the effective date of the revocation, or (2) the date that the HHA's last payable episode ends.

Nothing in 42 CFR §424.535(h) impacts the requirements of § 424.44 regarding the timely filing of claims.

F. Timeframe for Processing of Revocation Actions

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider or supplier's billing privileges, the contractor shall complete all steps associated with the revocation no later than 5 business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all of the revocation steps no later than 3 business days after these steps have been completed.

G. Provider Enrollment Appeals Process

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

H. 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:

- Preparing a draft revocation letter;
- E-mailing the letter to PEOG via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;
- Receiving PEOG's determinations and abiding by PEOG's instructions regarding the case;
- If PEOG authorizes the revocation:
 - Revoking the provider's billing privileges back to the appropriate date;
 - Establishing the applicable reenrollment bar;
 - Updating PECOS to show the length of the reenrollment bar;
 - Assessing an overpayment, as applicable; and
 - Affording appeal rights.

I. 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 or denied.

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

The contractor shall update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. The contractor 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

Denial Upheld

Denial 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 PEOG for certified providers or suppliers, contractors shall access the PEOG appeals 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 PEBFL.

J. Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- 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 25 of this chapter.

K. Overpayments Based Upon Revocations

In situations where a revocation is made with a prospective (i.e., 30 days from the date of CMS or the contractor's mailing of the revocation notification letter to the provider) effective date, the contractor's shall assess an overpayment back to a date when Medicare claims are determined to be ineligible for payment. This date may, but will not always, match the inactive date of the enrollment that is reflected in PECOS and MCS or FISS. The starting date upon which claims are not eligible for reimbursement is what the contractor's shall use to assess an overpayment, not the date the enrollment is inactive according to PECOS and MCS or FISS.

The contractor shall initiate procedures to collect overpayment after the appeal filing timeframe has expired or within 10 days of the final appeal determination by the contractor.

- 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.

15.27.3 - Other Identified Revocations

(Rev. 902, Issued: 09-27-19, Effective: 10-28-19, Implementation: 10-28-19)

MDPP Supplier Revocation for Use of an ineligible coach

1. General Procedures

42 CFR §424.205(h)(v) established a new revocation reason specifically for MDPP suppliers for a specific circumstance in which the MDPP supplier knowingly permitted an ineligible coach to furnish MDPP services to beneficiaries, despite being previously removed from the MDPP supplier's roster through a CAP.

If a MAC or ZPIC suspects this scenario, it shall develop a case file - including the reason(s) - and submit the file and all supporting documentation to the Provider Enrollment & Oversight Group (PEOG). The contractor shall provide PEOG with the information described in (2) below.

PEOG will review the case file and:

- Return the case file to the contractor for additional development, or
- Consider approving the contractor's recommendation for revocation.

If PEOG approves the revocation recommendation, PEOG will: (1) ensure that the applicable Medicare Administrative Contractor (MAC) is instructed to revoke the provider's/supplier's Medicare enrollment, and (2) notify the applicable contracting officer's representative (COR) in the Division of Medicare Integrity Contractor Operations of the action taken.

If the MAC receives a direct request from a ZPIC to revoke a provider's or supplier's Medicare enrollment, it shall refer the matter to its PEOG Business Function Lead (PEOG BFL) if it is unsure whether the ZPIC received prior PEOG approval for the revocation.

2. Revocation Request Data

The revocation request shall contain the following information:

- Provider/supplier name; administrative location(s); community setting(s) if applicable type (e.g., DMEPOS supplier); Provider Transaction Access Number; National Provider Identifier; applicable Medicare Administrative Contractor
- Name(s), e-mail address(es), and phone number(s) of investigators
- Tracking number
- Provider/supplier's billing status (Active? Inactive? For how long?)

- Whether the provider/supplier is a Fraud Prevention System provider/supplier
- Source/Special Project
- Whether the provider/supplier is under a current payment suspension
- Legal basis for revocation
- Relevant facts
- Application of facts to revocation reason
- Any other notable facts
- Effective date (per 42 CFR § 424.535(g))
- Supporting documentation
- Photos (which should be copied and pasted within the document)

3. Effective Dates

If revoked under this authority, the MDPP supplier does not have CAP rights. The revocation becomes effective 30 days after the contractor sends notice of the revocation.

4. Reenrollment Bar

As stated in 42 CFR §424.205(h), if an MDPP supplier, owner, or managing employee has 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. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.

5. Processing information

Refer to 15.27.2.E-H for additional processing information that also apply to this revocation reason.

15.27.4 - External Reporting Requirements

(Rev. 936; Issued: 01-31-20; Effective: 05-01-20; Implementation: 05-01-20)

A. Monthly

Using the existing template, the MAC shall capture the following information for all denied Form CMS-855 and Form CMS-20134 paper and web applications (to include those entered in PECOS and those not entered in PECOS). Denials from Form CMS-20134 shall be listed separately:

- LBN of the provider/supplier
- NPI
- State
- Contractor ID
- The denial reason (For any applications denied using the ‘Other (CMS Only)’ reason in PECOS, the MAC shall specify the denial reason in column U)
- If the denial was entered in PECOS (Y/N)

The reports shall be sent to the Provider Enrollment & Operations Group (with a copy to the MAC’s Contracting Officer's Representative (COR)) no later than the 15th of each month; the report shall cover the prior month’s denials (e.g., the February report shall cover all January denials).

15.27.5 – Rebuttal Process

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

A. Background

Pursuant to 42 C.F.R. § 424.545(b), a provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374. A rebuttal is an opportunity for the provider or supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per deactivation. Additional rebuttal requests shall be dismissed.

If an application is received for a deactivated provider or supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application in accordance with current processing instruction. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless the submitted application is required to reactivate the provider’s or supplier’s enrollment. If an application, received while a rebuttal submission is pending, is approved prior to the issuance of a rebuttal determination and results in the provider’s or supplier’s enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

Providers and suppliers may submit a rebuttal request for the following deactivation reasons, in accordance with 42 C.F.R. § 424.540(a):

- (1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.
- (2) The provider or supplier does not 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. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).
- (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.

B. Notification Letters for Deactivations

If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities identified in 42 C.F.R. § 424.540, the contractor shall deactivate the provider's or supplier's Medicare billing privileges unless another CMS direction is applicable. If a revocation authority is applicable, the contractor shall follow the current revocation instruction in 15.27.2, in lieu of deactivating the enrollment. If no revocation authority is applicable, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider's or supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via email if a valid email address is available. The contractor should also send via fax if a valid fax number is available. All notifications shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

15.27.5.1 – Rebuttal Submissions

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

A. Requirements and Submission of Rebuttals

The rebuttal submission:

- 1) Must be received by the contractor within 20 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, email, and/or fax;

- 2) Must specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement;
- 3) Should include all documentation and information the provider or supplier would like to be considered in reviewing the deactivation;
- 4) Must be submitted in the form of a letter that is signed and dated by the individual provider, supplier, the authorized or delegated official, or a legal representative, as defined in 42 C.F.R. § 498.10. If the legal representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the legal representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed and dated by the individual provider or supplier, the authorized or delegated official, or a legal representative.

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15 calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission is not appropriately signed and no response is received to the development request (if applicable), untimely (as described above), does not specify the facts or issues with which the provider or supplier disagrees and the reasons for disagreement, or is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable model rebuttal dismissal letter. The contractor may make a good cause determination so as to accept any rebuttal that has been submitted beyond the 20 calendar day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider's or supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

B. Time Calculations for Rebuttal Submissions

The date of receipt of a deactivation notice is presumed to be 5 days after the date on the deactivation notice unless there is a showing that it was, in fact, received earlier or later.

Therefore, the rebuttal must be received within 20 calendar days from the date of the deactivation notice to be considered timely. If the 20th calendar day from the date on the deactivation notice falls on a weekend or federally recognized holiday, then the rebuttal shall be accepted as timely if received by the next business day.

Consider the following example:

A deactivation notice is dated April 8, 2018. The provider or supplier is presumed to have received the deactivation notice on April 13, 2018. The provider or supplier submits a rebuttal that is received on April 28, 2018. The 20th calendar day from the date on the deactivation notice is April 28, 2018. However, since April 28, 2018 is a Saturday (weekend day), the rebuttal submission received on April 30, 2018 is considered timely because April 30, 2018 is the next business day following the 20th calendar day from the date on the deactivation notice.

It is the provider's or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

C. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar days of receipt of the accepted rebuttal request using the model rebuttal acknowledgment letter, including a rebuttal tracking number. The acknowledgement letter shall also be sent via email, if a valid email address is available. It is optional for the contractor to send the acknowledgement letter via fax, if a valid fax number is available.

The contractor shall process all accepted rebuttal submissions within 30 calendar days of the date of receipt. If while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued.

The contractor's review shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider or supplier shall be considered by the contractor in their review.

- 1) For deactivations under 42 C. F. R. § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the twelve month period preceding the date of deactivation, starting with the 1st day of the 1st month twelve months prior to the date of deactivation. If it is confirmed that billing occurred within twelve months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the twelve month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination.

Consider the following example:

Dr. Awesome has been enrolled in the Medicare program since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2016. Dr. Awesome's enrollment is deactivated effective January 1, 2018. Dr. Awesome timely submits a rebuttal statement regarding the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is confirmed that Dr. Awesome had not submitted claims since January 2016. Therefore, an unfavorable determination would be appropriate in this scenario, as the deactivation was justified.

- 2) For deactivations under 42 C. F. R. § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within 90 calendar days of when the change occurred. If information was submitted properly and timely, the contractor shall approve the rebuttal request and reinstate the provider's or supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, as the deactivation was justified. In making this determination, the contractor shall consider, at minimum, the following.
 - a. Whether the deactivation was implemented after 90 days of when the change of enrollment information occurred.
 - b. Whether the letter notifying the provider or supplier of the deactivation was sent to the correct address as instructed in section 15.24.
 - c. Whether the enrollment changes were received in an enrollment application that was processed to completion within 90 days of when the change of enrollment occurred.

Consider the following example:

Dr. Happy has reassigned his benefits to physician group Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's billing privileges are revoked effective January 1, 2018. Dr.

Happy's enrollment is deactivated on April 15, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal to the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 90 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 90 days of the change of enrollment information. Though an application was received within 90 days of the change of enrollment information, that application was not processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

- 3) For deactivations under 42 C. F. R. 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished 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. In making this determination, the contractor shall consider, at minimum, the following.
 - a. Whether the deactivation was implemented after 90 days of the revalidation request.
 - b. Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 15.24.
 - c. Whether a revalidation application was timely received that was processed to completion.

Consider the following example:

On January 1, 2018, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2018. The contractor receives a revalidation application from Dr. Great on March 1, 2018. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2018 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2018. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of

the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contractor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission shall be sent via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider or supplier's Medicare billing privileges within ten business days of the date the favorable determination is issued. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contractor issues a rebuttal determination unfavorable to the provider or supplier, the provider's or supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If additional information/documentation is needed prior to reinstating the provider or supplier (e.g. deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in their rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider or supplier to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

D. Rebuttal Determination is Not Subject to Further Review

Pursuant to the rebuttal regulation at 42 C.F.R. § 405.375(c), a determination made regarding a rebuttal request is not an initial determination and is not subject to

further review. Therefore, no additional appeal rights shall be included on any rebuttal determination letter.

15.27.5.2 – Rebuttal Model Letters

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

A. Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.

B. Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 15, Section 15.27.5.1. [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

C. Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD], [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

D. Rebuttal Moot Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

E. Rebuttal Withdrawn Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[MAC Name]

F. Rebuttal Receipt Acknowledgement Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. Final Rebuttal Decision Email Template

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

Dear [Name of the person(s) who submitted the rebuttal]:
Please see the attached determination regarding your rebuttal.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Rebuttal Dismissal Model Letters

1. Untimely

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 20 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Improper Signature

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]
[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within 20 calendar days of the date of the deactivation letter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

3. No Rebuttal Rights

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name].

[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

4. More than One Submission

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 15 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. Rebuttal Not Actionable Model Letter (Moot)

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May
be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Favorable Rebuttal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)(1-3)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- Medicare Program Integrity Manual (MPIM) chapter 15.XX (If applicable).

EXHIBITS:

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(**Example:** On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result,

[MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges is not justified based on the information available.

This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

K. Unfavorable Rebuttal Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)(1-3)

OTHER APPLICABLE AUTHORITIES:

- 42 C.F.R. §
- Medicare Program Integrity Manual chapter 15.XX (If applicable)

EXHIBITS:

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the rebuttal.]

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-3) is justified.)

This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

15.27.5.3 – Rebuttal Reporting Requirements

(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)

A. Monthly

Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column should be left blank.

The response in the column labelled “Final Decision Result” should be one of the following:

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved.
- **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation was not justified and the enrollment record has been placed back into an approved status.
- **Unfavorable (to provider/supplier):** MAC has determined that the deactivation was justified and the enrollment record remains deactivated.
- **Dismissed:** The appeal does not meet the rebuttal submission requirements. (Ex: incorrect signature, untimely, not rebuttable, etc.)
- **Rescinded:** MAC has received instruction from CMS to rescind the deactivation and return the enrollment record to an approved status.
- **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its rebuttal.

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall cover the prior month’s rebuttal submissions (e.g., the February report shall cover all January rebuttals). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

15.28 – Deceased Practitioners

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. Reports of Death from the Social Security Administration (SSA)

Contractors, including the NSC MAC, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities described below.

B. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners and/or Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

If the person is an owner, sole owner of a professional corporation or professional association, managing employee, director, officer, authorized official, etc., the

contractor shall verify and document that the person is deceased using the process described in section (C)(1) below.

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR §424.57(c)(2).)

The contractor need not, however, solicit a Form CMS-855 change request if the organization is enrolled with another contractor. Here, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

C. Reports of Death from Third-Parties

1. Verification

If a contractor, including DME MACs or the NSC MAC, receives a report of death from a third-party (state provider association, state medical society, academic medical institution, etc.), the contractor shall verify that the physician, non-physician practitioner or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits;
- Obtaining an obituary notice from the newspaper;
- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);
- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or
- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

2. Post-Confirmation Actions

Once the contractor verifies the death, it shall:

1. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.
2. Search PECOS to determine whether the individual is listed therein as an owner, sole owner of a professional corporation or professional association, managing employee, director, officer, partner, authorized official, or delegated official of another supplier.
3. If the person is not in PECOS, no further action with respect to that individual is needed.
4. If the supplier is indeed identified in PECOS as an owner, officer, etc., the contractor shall notify the organization with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with §424.57(c)(2).)

The contractor need not, however, ask for a Form CMS-855 change request if the organization is enrolled with another contractor. In this situation, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

The contractor shall place verification documentation in the provider or supplier file in accordance with section 15.7.3 of this chapter.

D. Education & Outreach

Contractors, including DME MACs and the NSC MAC, shall conduct outreach to state provider associations, state medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death of physicians and non-physician practitioners participating in the Medicare program.

E. Trustees/Legal Representatives

1. NPI - The trustee/legal representative of a deceased physician, non-physician practitioner or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.
2. Special Payment Address - In situations where a physician, non-physician

practitioner or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the physician, non-physician practitioner or DMEPOS supplier's estate to change the physician, non-physician practitioner or DMEPOS supplier's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.
- Any evidence – within reason - verifying that the physician, non-physician practitioner or DMEPOS supplier is in fact deceased.
- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner or DMEPOS supplier's estate.

The policies in this section 15.28(E)(1) and (2) apply only to physicians, non-physician practitioners, sole owners of a professional corporation or professional association, and DMEPOS suppliers who operated their business as sole proprietors. It does not apply to situations in which the physician or non-physician practitioner reassigned his or her benefits to another entity.

F. Proof of Life Documentation

On rare occasions erroneous death information may be received through the DMF process that results in systematic enrollment deactivations in PECOS or records populated on the Deceased Associates reports in PECOS for MAC deactivation actions. In order for the providers/suppliers to reactivate their enrollments and have the date of death removed from their PECOS records, MACs shall request documentation that supports "proof of life" (for example, Retirement, Survivors, and Disability Insurance document issued by SSA). In the event a provider/supplier is unable to obtain such documentation, the MAC shall submit a request to their PEOG Business Function Lead (BFL) containing the provider/supplier's name, date of birth and SSN so that CMS can confirm proof of life with SSA.

15.29 - Provider and Supplier Revalidations

(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

The contractor shall follow the guidance provided in sections 15.29.1 through 15.29.10 when processing revalidation applications, unless indicated otherwise in another CMS directive. Also, this guidance takes precedence over all others instructions in this chapter 15 with respect to revalidation processing unless, again, another CMS directive specifies otherwise.

Consistent with section 6401(a) of the Patient Protection and the Affordable Care Act (ACA), all existing providers and suppliers are required to revalidate their enrollment information under new enrollment screening criteria. Providers and suppliers are normally required to revalidate their Medicare enrollment every 5 years (every 3 years for suppliers of Durable Medical Equipment, Prosthetics Orthotics and Supplies (DMEPOS)). However, CMS reserves the right to perform off-cycle revalidations as deemed necessary.

15.29.1 – Revalidation Lists

(Rev. 782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

The CMS will identify the providers and suppliers required to revalidate during each cycle. CMS will communicate when new lists become available through the appropriate channels, at which time the contractor shall obtain the list from the CGI Share Point Ensemble website.

The list will contain a suggested revalidation due date, consisting of a month and day of the year, to assist MACs in staggering their workload and distributing the e-mails or mailings evenly. MACs shall review the list and may alter a provider/suppliers' due date month based on staffing levels and workload. However, the day that the revalidation is due shall always remain as the last day of each month (i.e., June 30th, July 31st, or August 31st). When distributing the workload, MACs shall ensure that the revalidation due dates are divided equally over a 6 month period and accounts for fifty percent of the MAC's list (i.e., 50 percent of the revalidation due dates are defined in the first 6 months, and the remaining 50 percent in the last 6 months). MACs shall also ensure that the due dates selected do not go beyond the current year.

Once the MAC confirmed lists are received by CMS, a final list will be generated capturing the provider/supplier's due date and timeframes for each revalidation action (i.e., e-mail or mail date, pend, deactivation). The list will be posted to the CGI Share Point Ensemble site and will be refreshed with updated enrollment data every 60 days to account for providers/suppliers who have been deactivated or have had changes in the provider/supplier's enrollment information. MACs shall use the most current list available to conduct their e-mails or mailings and shall allow sufficient time for the provider/supplier to meet their deadline (between 90 to 105 days prior to the revalidation due date).

This list will also be made available on <https://data.cms.gov/revalidation> so that providers and suppliers are aware of who has been selected to revalidate.

15.29.2 – Mailing Revalidation Letters

(Rev. 782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

Based on the due date identified on the list, MACs shall send a revalidation notice

between 90 to 105 days prior to the revalidation due date using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5. The initial revalidation letter may include a generic provider enrollment signature; however, development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts. MACs may send revalidation notices via email if this option is in line with the MAC's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of PECOS). When sending revalidation notices via email, MACs shall indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate this from other emails. The sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the revalidation notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, MACs are not required to mail a revalidation notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 90 to 105 day timeframe prior to the revalidation due date. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the MAC chooses the mail option, MACs shall mail two revalidation notices to the provider/supplier's correspondence and special payment address and/or practice location address using the instructions outlined above.

When issuing revalidation notices to individual group members, MACs shall provide on the revalidation notice identifying information of the organization (s) (i.e., Legal Business Name (LBN), Doing Business As (DBA) name, Tax Identification Number) that the provider reassigns benefits in lieu of including the provider's PTANs. Individual group members may be more familiar with the LBN or DBA name of the organizations they are associated versus the PTANs. This should eliminate MACs developing for PTANs not included on the revalidation application.

If one of the locations is found to be incorrect or the letter gets returned as undeliverable, the contractor shall re-send the returned letter to an address not used for the initial mailing. If it is determined that all locations are the same and the contractor has exhausted all reasonable means of contacting the provider/supplier, the contractor shall deactivate the provider/supplier's enrollment in either MCS/FISS or PECOS, whenever possible.

15.29.3 – Non-Response to Revalidation Actions

(Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

15.29.3.1 – Phone Calls

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

MACs may continue to contact providers/suppliers via telephone or email to communicate non-receipt of revalidation applications; however, these contacts are not required.

If telephone or email contacts are made, MACs shall continue to document all communications with the providers/suppliers.

15.29.3.2 – Pend Status

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

MACs shall apply the payment hold (pend flag) in PECOS if the provider/supplier fails to respond to the revalidation request. MACs shall perform this action within 25 days after the revalidation due date. MACs may, but are not required to notify the provider/supplier of the payment hold.

Since there is no way to assign a payment hold to an individual group member without it preventing payment to the entire group, MACs shall issue a letter to the individual group members in lieu of the payment hold within 25 days after the revalidation due date using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 (Revalidation Past Due Group Member Sample Letter). MACs may send the payment hold notice via email if this option is in line with the MAC's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of the Provider Enrollment Chain and Ownership System (PECOS)). When sending payment hold notices via email, MACs shall indicate "URGENT: Revalidation Past Due" in the subject line to differentiate this from other emails. The letter should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the payment hold notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, MACs are not required to mail a payment hold notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper payment hold notices shall be mailed to the provider/supplier's correspondence and special payment addresses. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the MAC chooses the mail option, MACs shall mail the two payment hold notices to the provider/supplier's correspondence and special payment address and/or the practice location address using the instructions outlined above.

This requirement shall only apply to individual group members who are reassigned to a group and/or providers who have employment arrangements.

15.29.3.3 – Deactivation Actions

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

MACs shall deactivate a provider/supplier's enrollment record for failure to respond to the revalidation request between days 60 – 75 after the revalidation due date and notify the provider/supplier using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 (Stopping Billing Privileges Sample Letter).

The MAC shall establish the effective date of deactivation as the same date the action is being taken.

If an individual provider is deactivated for failure to respond to a revalidation request, the contractor shall search the provider's associate record to determine if the provider is identified as a supervising physician on any independent diagnostic testing facility (IDTF) enrollments. If so, the provider shall be disassociated as the supervising physician for that entity. If the deactivated provider is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

15.29.4 - Receipt of Revalidation Application

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

MACs shall return all unsolicited applications. Unsolicited applications are: (1) revalidation applications received more than seven months prior to the provider/suppliers established due date and/or (2) Providers and suppliers identified as TBD (To Be Determined) on the revalidation look up tool. MACs shall return these applications using the sample return letter template provided in Pub. 100-08, chapter 15, section 15.24.5, within 20 business days of receipt. MACs shall also submit a request to CMS to have the application fee returned to the provider. Revalidation applications submitted within seven months of their due date shall be accepted and processed by the MAC. The submission date of a revalidation application for providers/suppliers who are on the CMS posted list will not alter their future revalidation due date.

The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization.

If a provider/supplier wishes to voluntarily withdraw from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail or fax from the individual provider or the AO/DO (on letterhead); the contractor shall not require the provider/supplier to complete a CMS-855 application. If the request is made via telephone, the contractor shall document the telephone conversation (in accordance with section 15.7.3 of this chapter) and take the appropriate action in PECOS.

Any subunit that has a separate provider agreement (e.g., home health agency (HHA) subunits) it must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the subunit has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the revalidation can be disclosed on the main provider's Form CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity. Separate fees are not required.

If the provider/supplier requests to collapse its PTANs as a result of revalidation, the MAC shall process those requests, if appropriate (based on payment localities, etc.).

15.29.4.1 – Revalidation Application Received and Development Required

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

If the revalidation application is received but requires development (i.e., missing application fee, hardship request, reassignments and/or employment arrangements, documentation, signature, etc.), the MAC shall notify the provider or supplier via mail, phone, fax or email. MACs shall develop for all of the missing information in one development request. Providers and suppliers shall be given 30 days to respond to the MAC's request and may submit the missing information via mail, fax, or email containing scanned documentation (this includes missing signatures and dates). The provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post revalidation application approval.

If licensure and/or educational requirements (i.e., non-physician practitioner's degree or diploma) can be verified online, the MAC shall not require the provider/supplier to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again with their revalidation application. The MAC may utilize the existing documentation for verification. Residency information shall also

not be required as part of revalidation. The MAC shall not require further development for data that is missing on the provider/supplier's revalidation application if the information is disclosed (1) elsewhere on the application, or (2) in the supporting documentation submitted with the application with the exception of the following items:

- Adverse legal action data
- Legal business name (LBN)
- Tax identification number (TIN)
- NPI-legacy number combinations
- Supplier/Practitioner type
- "Doing business as" name
- Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

MACs shall not require providers/suppliers to include the PTAN(s) in section 2 or 4 on the revalidation application, provided they have included the necessary information (NPI, TIN, LBN, DBA, etc.) for the MACs to appropriately make the association. If the PTAN is not submitted but is needed to make the connection, MACs shall use the shared systems, PECOS or their provider files as a resource before developing back to the provider/supplier.

MACs shall not develop for the EFT form if the provider/supplier has either the 05/2010 or 09/13 version of CMS 588 (EFT) on file. If an EFT form is submitted along with a bank letter or voided check, MACs may verify that the LBN matches and develop to process the application accordingly.

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

In scenarios where a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments and/or employment arrangements, the MAC shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassignments and/or employment arrangements not accounted for. If no response is received within 30 days, the MAC shall revalidate the single reassignment and deactivate the

reassignments and/or employment arrangements within the enrollment records that were not revalidated.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc).

To illustrate, in scenario #1 the MAC issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the MAC but only addresses the reassignment for Group A. The MAC develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application is still considered in progress, the provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignment information, even post revalidation application approval. The revalidation application is processed to completion and the provider experiences no break in billing.

In scenario #2 the MAC issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the MAC but only addresses the reassignment for Group A. The MAC develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days and the revalidation due date has passed. Group A's reassignment is revalidated. Group B & C's reassignments and/or employment arrangements are deactivated effective with the date deactivation action is taken due to non-response or incomplete response to a development request. The approval letter issued by the MAC will identify the reassignments and/or employment arrangements that were revalidated and those terminated with the effective date of the reassignment or termination. The provider is required to submit a full application (CMS-855R) to reactivate the reassignment. The effective date for the reactivation is based on the receipt date of the CMS-855R. In this scenario the provider does experience a break in billing.

In this scenario, the entire enrollment shall not be deactivated; only the non-response reassignments and/or employment arrangements shall be deactivated and the other reassignments and/or employment arrangements revalidated.)

If other missing information is not received within 30 days, MACs shall deactivate the provider/supplier within 25 days after the development due date and notify the provider/supplier of the deactivation using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5. After deactivation, the provider shall be required to submit an entirely new application in order to reactivate their PTANs. Supporting documentation received may be used, if needed, for subsequent application submissions.

15.29.4.2 – Revalidation Received after a Pend is Applied
(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

The contractor shall remove the pend within 15 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail, fax, or email a decision letter to the provider or supplier to notify it that the revalidation application has been processed.

15.29.4.3 – Revalidation Received After a Deactivation Occurs
(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

MACs shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The MAC shall process the application as a reactivation. The provider/supplier shall maintain their original PTAN but the MAC shall reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN using Action Reason (A/R) codes in the Multi-Carrier Claims System (MCS) based on the receipt date of the application along with applying the retrospective billing date if appropriate. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated for non-response to revalidation). This requirement also applies to group members whose reassignment association was terminated when the group was deactivated.

Since the issuance of PTANs and effective dates for Part A certified providers/suppliers, including ASC's and Portable X-Ray, are determined by the RO and the deactivation action does not terminate their provider agreement, MACs shall allow the provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed.

When processing the revalidation application after a deactivation occurs, the contractor shall not:

- Require any provider/supplier whose PTAN(s) have been deactivated to obtain a new State survey or accreditation as a condition of revalidation.

15.29.4.4 – Change of Information Received Prior to or After the Revalidation Letter is Mailed
(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

If a change of information (COI) application is received from the provider/supplier

prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

If the provider/supplier submits an application marked as a revalidation but only includes enough information to be considered a COI, the contractor shall: (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

If a change of information (COI) application is received after the contractor has mailed the revalidation notice, the contractor shall: (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

15.29.4.5 – Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed (Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

If the revalidation due date has been posted (seven months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that seven month timeframe, MACs shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and MACs shall not develop for the missing information, since they were established after the revalidation notice was issued. MACs shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.

To illustrate, Dr. Doe submits a CMS-855R application to his MAC to add a new reassignment to Browns Medical Center. Soon after he checks <https://data.cms.gov/revalidation> and notices that he is due for revalidation in the next 7 months. He submits his revalidation application to his MAC but does not include the reassignment for Browns Medical Center since it is in progress and an approval notification has not been issued. The MAC finalizes the reassignment changes and then proceeds with processing the revalidation application. The MAC shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

If a revalidation and change of information application is received concurrently, the MACs shall merge the two applications and process accordingly.

15.29.5 – Revalidating Providers Involved in a Change of Ownership (CHOW)

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

MACs shall not take revalidation actions on providers or suppliers that are undergoing a CHOW that is currently in process by the MAC or pending review by the State/RO. MACs shall notify their BFL if a seller enrollment record is up for revalidation and the CHOW application is currently in process by the MAC. MACs shall include the seller and buyer enrollment record ID in their email notification to their BFL.

15.29.6 – Reserved for Future Use

(Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)

15.29.7 – Large Group Revalidation Coordination

(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)

In addition to providing the finalized revalidation list with MAC confirmed due dates, CMS will provide a list of large groups affected by this notification, including the individual providers reassigning benefits to their group that appear on the seven month list. MACs may stagger the large group mailings however they see fit to ensure the group receives notification that providers within their group will be receiving a request to revalidate in the next seven months. MACs shall send the notification letter to the Authorized/Delegated Official or the enrollment contact person. MACs may send the group notices via email utilizing the email addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS). MACs shall indicate **“IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request”** in the subject line to differentiate this from other emails. MACs shall use the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 to notify the large groups by attaching the letter in the body of the email. The letter should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the group notice if sent via email. If all of the emails the notice is sent to are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier’s correspondence and special payment addresses, within the 90 to 105 day timeframe. MACs do not need to mail a notification if one or a few of the emails are returned as undeliverable, but one or more have been delivered successfully. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier’s practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record, then MACs shall mail the notice to the group’s correspondence address.

MACs shall include with the notification letter a spreadsheet identifying the individual providers that will be revalidated. The spreadsheet shall contain the Provider's Name, National Provider Identifier (NPI) and Specialty. This information will be provided as part of the list supplied by CMS.

The large group list will contain only those large groups consisting of 200 or more reassignments. Groups with less than 200 reassignments will not appear on the list and are not required to be emailed or mailed a group notification letter; however, all reassignment information will be available at <https://data.cms.gov/revalidation> for providers and suppliers to view.

MACs shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter. The enrollment analysts shall work directly with the group's enrollment contact person or the Authorized/Delegated Official on file.

MACs shall allow large groups to submit a spreadsheet identifying those providers that are no longer practicing at their group in lieu of submitting CMS-855R termination applications. The spreadsheet shall be accompanied by a letter signed by the Authorized/Delegated Official of the group. This process is only acceptable for large groups who are completing their revalidation and coordinating directly with the MAC.

15.29.8 – Finalizing the Revalidation Application

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

Prior to processing the revalidation application to completion, the contractor shall ensure that:

- A site visit (if applicable to the provider/supplier in question) is requested to be conducted by the National Site Visit Contractor (NSVC)
- The provider/supplier meets all applicable federal regulatory requirements regarding licensure, certification and/or educational requirements, as listed in the Code of Federal Regulations (CFR) and as described in CMS Publication 100-02 for his or her supplier type.
- The provider/supplier's information is revalidated based on the information in PECOS.
- Practice locations continue to be verified; however, there is no need to contact each and every location separately. Verification shall be done with the contact person listed on the application and noted accordingly in the contractor's verification documentation per section 15.7.3 of this chapter.

- The appropriate logging & tracking (L&T) record type and finalization status are identified in PECOS.
- An enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs yet not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, i.e., end-dated). If all PTANs have been addressed (i.e., revalidated, end-dated), the enrollment can be marked as revalidated.
- PECOS and the claims systems remain in sync. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation unless instructed otherwise in another CMS directive.
- When processing of the revalidation application is complete, MACs shall issue an approval letter to the contact person or the provider/supplier if a contact person is not listed, via mail, fax, or email. If the provider/supplier has reassignments that were terminated due to non-response, the approval letter shall contain the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

15.29.9 – Revalidation Reporting

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

MACs are no longer required to submit reports on the 5th and 20th of each month for Cycle 2. However, MACs shall maintain internally the method of delivery for the provider/supplier revalidation notices and the date the email or letter was sent. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but is not limited to the following; revalidation notification delivery date, delivery method, delivery address, deactivation date, provider response date, reactivation date, application finalization date, etc.

15.29.10 - Revalidation Files Available Online

(Rev. 685, Issued: 11-03-16, Effective: 09-06-16, Implementation: 09-06-16)

The revalidation due dates are available at <https://data.cms.gov/revalidation> via the Revalidation look up tool. The tool includes all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at <https://data.cms.gov/revalidation> on the CMS website.

15.29.11 – Revalidation Extension Requests

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

MACs shall only accept extension requests from a provider or supplier that was not given the full seven months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. MACs shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the MAC shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. MACs shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.

Transmittals Issued for this Chapter

| Rev # | Issue Date | Subject | Impl Date | CR# |
|-----------------|-------------------|--|------------------|------------|
| <u>R10138PI</u> | 05/15/2020 | Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment) | 06/16/2010 | 11546 |
| <u>R936PI</u> | 01/31/2020 | Provider Enrollment Appeals Procedure | 05/01/2020 | 11210 |
| <u>R926PI</u> | 11/22/2019 | Additional Guidance on Private Contracting/Opting-out of Medicare and Entering Opt-out Affidavit Records in the Provider Enrollment, Chain and | 12/24/2019 | 10939 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---------------|-------------------|---|------------------|------------|
| | | Ownership System (PECOS) | | |
| <u>R904PI</u> | 09/27/2019 | Provider Enrollment Rebuttal Process | 12/31/2019 | 10978 |
| <u>R902PI</u> | 09/27/2019 | Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08 | 10/28/2019 | 11425 |
| <u>R898PI</u> | 09/06/2019 | Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08, Program Integrity Manual, and to the CMS-855R Processing Guide | 10/07/2019 | 11371 |
| <u>R896PI</u> | 08/30/2019 | Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08 | 10/01/2019 | 11325 |
| <u>R882PI</u> | 05/24/2019 | Additional Processing Procedure for Adding a New Provider-Based Location for Critical Access Hospitals (CAHs) | 06/25/2019 | 11246 |
| <u>R865PI</u> | 02/21/2019 | Update to Chapter 15 of Publication (Pub.) 100-08 | 03/12/2019 | 10954 |
| <u>R862PI</u> | 02/08/2019 | Update to Chapter 15 of Publication (Pub.) 100-08- Rescinded and replaced by Transmittal 865 | 03/12/2019 | 10954 |
| <u>R824PI</u> | 09/05/2018 | Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies | 10/01/2018 | 10845 |
| <u>R822PI</u> | 08/24/2018 | Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies- Rescinded and replaced by Transmittal 824 | 10/01/2018 | 10845 |
| R797PI | 06/01/2018 | Reviewing for Adverse Legal Actions (ALA) | 04/30/2018 | 10558 |
| <u>R762PI</u> | 04/30/2017 | Update to Chapter 15 of Pub. 100-08 | 01/29/2018 | 10386 |
| <u>R782PI</u> | 03/30/2018 | Update to Chapter 15 of Publication 100-08 - Medicare Enrollment Deactivation Policies | 04/30/2018 | 10443 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---------------|-------------------|---|------------------|------------|
| <u>R784PI</u> | 03/30/2018 | Reviewing for Adverse Legal Actions (ALA) | 04/30/2018 | 10558 |
| <u>R773PI</u> | 02/23/2018 | Form CMS-855O Processing Guide | 03/23/2018 | 10355 |
| <u>R765PI</u> | 01/08/2018 | Medicare Diabetes Prevention Program (MDPP) Enrollment Process | 01/19/2018 | 10356 |
| <u>R734PI</u> | 07/28/2017 | Update to Reporting Requirements | 06/27/2017 | 9924 |
| <u>R719PI</u> | 05/26/2017 | Update to Reporting Requirements | 06/27/2017 | 9924 |
| <u>R718PI</u> | 05/19/2017 | Reviewing for Adverse Legal Actions (ALA) | 06/20/2017 | 9879 |
| <u>R717PI</u> | 05/12/2017 | Update to Pub. 100-08, Chapter 15 | 05/15/2017 | 9953 |
| <u>R715PI</u> | 05/11/2017 | Update to Pub. 100-08, Chapter 15 | 06/13/2017 | 9953 |
| <u>R711PI</u> | 04/25/2017 | Update to Pub. 100-08, Chapter 15 | 05/15/2017 | 9953 |
| <u>R710PI</u> | 04/14/2017 | Update to Pub. 100-08, Chapter 15 | 05/15/2017 | 9953 |
| <u>R689PI</u> | 12/09/2016 | Clarification of Certification Statement Signature and Contact Person Requirements | 01/09/2017 | 9776 |
| <u>R688PI</u> | 11/18/2016 | Update to Pub. 100-08, Chapter 15 | 07/26/2016 | 9635 |
| <u>R685PI</u> | 11/03/2016 | Incorporation of Cycle 2 Revalidation Policies | 09/06/2016 | 9628 |
| <u>R684PI</u> | 11/01/2016 | Incorporation of Cycle 2 Revalidation Policies – Rescinded and replaced by Transmittal 685 | 12/02/2016 | 9628 |
| <u>R681PI</u> | 10/27/2016 | Revision to Surety Bond Collection Procedures | 01/30/2017 | 9755 |
| <u>R676PI</u> | 09/16/2016 | Clarification of Certain Policies in Pub. 100-08, Chapter 15 Regarding the Processing of Form CMS-855R Applications | 12/19/2016 | 9552 |
| <u>R666PI</u> | 08/05/2016 | Incorporation of Cycle 2 Revalidation Policies - Rescinded and replaced by Transmittal 684 | 09/06/2016 | 9628 |
| <u>R659PI</u> | 06/24/2016 | Update to Pub. 100-08, Chapter 15 - Rescinded and replaced by Transmittal 688 | 07/26/2016 | 9635 |
| <u>R636PI</u> | 02/04/2016 | Update to Pub. 100-08, Chapter 15 | 03/04/2016 | 9390 |
| <u>R626PI</u> | 11/13/2015 | Update to Surety Bond Collection Requirements | 12/14/2015 | 9296 |
| <u>R609PI</u> | 08/14/2015 | Clarification Regarding the Processing of | 11/02/2015 | 9174 |

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| | | Certain Provider Enrollment-Related Transactions | | |
| <u>R605PI</u> | 07/31/2015 | Clarification Regarding the Processing of Certain Provider Enrollment-Related Transactions – Rescinded and replaced by Transmittal 609 | 11/02/2015 | 9174 |
| <u>R592PI</u> | 05/08/2015 | Update of Provider Enrollment Instructions in Chapter 15 of Pub. 100-08 | 06/08/2015 | 9139 |
| <u>R591PI</u> | 05/08/2015 | Revisions to Surety Bond Collection Policies | 06/08/2015 | 9123 |
| <u>R590PI</u> | 04/24/2015 | Update of CMS-855A, Physician-Owned Hospital Reporting Via the CMS-855POH and Indirect Payment Procedure Registration Via the CMS-855C in Chapter 15 of Pub. 100-08 | 05/25/2015 | 9120 |
| <u>R587PI</u> | 04/17/2015 | Clarification of Ordering and Certifying Documentation Maintenance Requirements | 07/20/2015 | 9112 |
| <u>R582PI</u> | 03/04/2015 | Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 05/28/2015 | 9065 |
| <u>R581PI</u> | 02/27/2015 | Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 – Rescinded and replaced by Transmittal 582 | 05/28/2015 | 9065 |
| <u>R578PI</u> | 02/25/2015 | Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 05/15/2015 | 9011 |
| <u>R575PI</u> | 02/13/2015 | Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 – Rescinded and replaced by Transmittal 578 | 05/15/2015 | 9011 |
| <u>R561PI</u> | 12/12/2014 | Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 04/18/2015 | 8901 |
| <u>R556PI</u> | 11/26/2014 | Revisions to Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 12/29/2014 | 8810 |
| <u>R539PI</u> | 08/29/2014 | Cardiac Rehabilitation Programs for | 08/18/2014 | 8758 |

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| | | Chronic Heart Failure – Rescinded and replaced with Transmittal 539 | | |
| <u>R532PI</u> | 08/01/2014 | Incorporation of Various Form CMS-855 Processing Activities into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 09/02/2014 | 8842 |
| <u>R530PI</u> | 07/18/2014 | Cardiac Rehabilitation Programs for Chronic Heart Failure – Rescinded and replaced with Transmittal 539 | 08/18/2014 | 8758 |
| R525PI | 06/27/2014 | Update to Form CMS-855 Application Processing Sections of CMS Pub. 100-08, Chapter 15 | 07/29/2014 | 8637 |
| R521PI | 06/13/2014 | Submission of Community Mental Health Center (CMHC) Certifications of Compliance with Section 485.918(b)(1) | 07/15/2014 | 8784 |
| R519PI | 05/30/2014 | Revision to CMS Publication 100-08, Chapter 15 | 07/31/2014 | 8512 |
| R517PI | 05/16/2014 | Update to Surety Bond Collection Procedures | 06/17/2014 | 8636 |
| R514PI | 05/02/2014 | Update to CMS Publication 100-08, Chapter 15 | 06/03/2014 | 8682 |
| R509PI | 03/27/2014 | Change in Provider Enrollment Timeliness Standards | 06/02/2014 | 8551 |
| R507PI | 02/28/2014 | Change in Provider Enrollment Timeliness Standards – Rescinded and replaced by Transmittal 509 | 05/29/2014 | 8551 |
| R503PI | 01/24/2014 | Inter-Jurisdictional Reassignments | 02/25/2014 | 8545 |
| R502PI | 01/17/2014 | Registration of Entities Using the Indirect Payment Procedure (IPP) | 01/06/14 | 8284 |
| R499PI | 12/27/2013 | Update to Chapter 15 of the Program Integrity Manual | 01/28/2014 | 8544 |
| R494PI | 12/06/2013 | Registration of Entities Using the Indirect Payment Procedure (IPP) | 01/06/14 | 8284 |
| R492PI | 12/06/2013 | Additional Updates to Chapter 15 of the Program Integrity Manual (PIM) | 01/07/2014 | 8393 |
| R490PI | 11/06/2013 | Reassignment to Part A Critical Access Hospitals Billing Under Method II (CAH II) | 01/06/2014 | 8387 |
| R483PI | 08/16/2013 | Reassignment to Part A Critical Access | 01/06/2014 | 8387 |

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| | | Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) – Rescinded and replaced by Transmittal 490 | | |
| R479PI | 08/01/2013 | Enrollment Denials When an Existing or Delinquent Overpayment Exists | 10/07/2013 | 8039 |
| R478PI | 08/02/2013 | Registration of Entities Using the Indirect Payment Procedure (IPP) – Rescinded and replaced by Transmittal 494 | 01/06/2014 | 8284 |
| R474PI | 07/05/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) | 10/08/2013 | 8341 |
| R471PI | 06/11/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) | 05/28/2013 | 8222 |
| R470PI | 05/31/2013 | Revision to Surety Bond Collection Process | 07/01/2013 | 8283 |
| R469PI | 05/31/2013 | Enrollment Denials When an Existing or Delinquent Overpayment Exists – Rescinded and replaced by Transmittal 479 | 10/07/2013 | 8039 |
| R463PI | 05/17/2013 | Model Letter Revisions | 06/07/2013 | 8117 |
| R462PI | 05/16/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) | 03/18/2013 | 8155 |
| R461PI | 04/26/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 471 | 05/28/2013 | 8222 |
| R459PI | 04/12/2013 | Tax Identification Numbers of Foreign Owning and Managing Entities and Individuals | 05/13/2013 | 8258 |
| R457PI | 04/02/2013 | Model Letter Revisions – Rescinded and replaced by Transmittal 463 | 04/22/2013 | 8117 |
| R456PI | 03/22/2013 | Model Letter Revisions – Rescinded and replaced by Transmittal 457 | 04/22/2013 | 8117 |
| R450PI | 02/15/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 462 | 03/18/2013 | 8155 |
| R445PI | 12/14/2012 | Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM) | 01/01/2014 | 7864 |
| R440PI | 11/23/2012 | Revisions to Appeals Section of Chapter 15 of the Program Integrity Manual (PIM) | 12/24/2012 | 8110 |

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| R437PI | 11/02/2012 | Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 445 | 02/01/2013 | 7864 |
| R435PI | 10/19/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part IX | 11/20/2012 | 8019 |
| R433PI | 09/07/2012 | Review of Debarment List and Processing of Tie-in Notices | 10/09/2012 | 8020 |
| R431PI | 08/31/2012 | Ordering and Certifying Documentation-Maintenance Requirements | 10/01/2012 | 7890 |
| R430PI | 09/28/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VIII | 10/29/2012 | 7889 |
| R424PI | 06/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VI | 06/19/2012 | 7827 |
| R423PI | 06/01/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VII | 07/02/2012 | 7839 |
| R421PI | 05/18/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VI – Rescinded and replaced by Transmittal 424 | 06/19/2012 | 7827 |
| R416PI | 04/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part III | 02/27/2012 | 7698 |
| R415PI | 04/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part V | 05/14/2012 | 7797 |
| R414PI | 04/06/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part IV | 05/07/2012 | 7763 |
| R412PI | 03/30/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part II | 04/30/2012 | 7646 |
| R410PI | 03/02/2012 | Instructions for Processing Form CMS-8550 Submissions | 06/04/2012 | 7723 |
| R408PI | 02/22/2012 | Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators | 02/03/2012 | 7363 |
| R407PI | 02/09/2012 | Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures(This CR Fully Rescinds and Replaces CR 7177) | 01/27/2012 | 7681 |
| R405PI | 01/26/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM) –Part III | 02/27/2012 | 7698 |

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| | | – Rescinded and replaced by Transmittal 416 | | |
| R404PI | 01/20/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part I | 04/22/2012 | 7579 |
| R403PI | 01/20/2012 | Claims Against Surety Bonds for Suppliers of Durable Medicare Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) | 02/21/2012 | 7167 |
| R402PI | 01/13/2012 | Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures(This CR Fully Rescinds and Replaces CR 7177) – Rescinded and replaced by Transmittal 407 | 01/27/2012 | 7681 |
| R400PI | 11/21/2011 | Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 408 | 02/03/2012 | 7363 |
| R394PI | 10/27/2011 | Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 400 | 02/03/2012 | 7363 |
| R392PI | 10/14/2011 | Update to Notifications Sent to State Medicaid Agencies and Child Health Plans of Medicare Terminations for Certified Providers and Suppliers and Medicare Revocations for Providers and Suppliers. This CR rescinds and fully replaces CR 7017, 7074 and 7334 | 11/15/2011 | 7532 |
| R388PI | 09/16/2011 | Additional Review Activities for Home Health Agencies (HHAs) | 12/17/2011 | 7525 |
| R387PI | 09/01/2011 | Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare Beneficiaries | 10/18/2010 | 7097 |
| R380PI | 08/03/2011 | Advanced Diagnostic Imaging Accreditation Enrollment Procedures | 07/05/2011 | 7177 |
| R374PI | 05/06/2011 | Update to Notifications Sent to State Medicaid Agencies and Child Health | 06/06/2011 | 7334 |

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| | | Plans of Medicare Terminations for Certified Providers and Suppliers and Medicare Revocations for Providers and Suppliers | | |
| R373PI | 04/07/2011 | Advanced Diagnostic Imaging Accreditation Enrollment Procedures – Rescinded and replaced by Transmittal 380 | 07/05/2011 | 7177 |
| R372PI | 03/25/2011 | Effective Date of Certified Provider or Supplier Agreement or Approval | 04/25/2011 | 7232 |
| R371PI | 03/23/2011 | Implementation of Provider Enrollment Provisions in CMS-6028-FC | 03/25/2011 | 7350 |
| R369PI | 03/11/2011 | Advanced Diagnostic Imaging Accreditation Enrollment Procedures – Rescinded and replaced by Transmittal 373 | 06/12/2011 | 7177 |
| R365PI | 01/28/2011 | Diabetes Self-Management Training (DSMT) | 04/29/2011 | 7236 |
| R363PI | 01/14/2011 | Clarification for Part A Contractors Including Audit and Claims Intermediaries Notifying Each Other via E-mail Upon Processing of the Initial Enrollment Application, Change of Information, Voluntary Termination, or Any Other CMS-855 Transaction | 02/15/2011 | 7221 |
| R358PI | 10/29/2010 | Indian Health Service (IHS) Facilities and Tribal Provider’s Use of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) | 11/29/2010 | 7174 |
| R357PI | 10/01/2010 | Durable Medical Equipment (DME MAC) and the National Supplier Clearinghouse (NSC MAC) Procedures for Third Party Notification of Deceased Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Supplier Associates | 10/04/2010 | 6714 |
| R356PI | 09/24/2010 | Manual Redesign | 10/26/2010 | 7083 |
| R355PI | 09/17/2010 | Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare | 10/18/2010 | 7097 |

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| | | Beneficiaries | | |
| R354PI | 08/27/2010 | Manual Redesign | 09/28/2010 | 7016 |
| R353PI | 08/27/2010 | Notification to State Medicaid Agencies and Child Health Plans of Medicare Terminations for Certified Providers and Suppliers | 09/28/2010 | 7074 |
| R350PI | 08/20/2010 | Notification to State Medicaid Agencies and Child Health plans of Medicare Revocation | 09/21/2010 | 7017 |
| R347PI | 07/15/2010 | Chapter 10 Manual Redesign - Initial release of Chapter 15 | 07/30/2010 | 6938 |
| R346PI | 06/25/2010 | Guidance on Implementing Section 3109 of the Patient Protection and Affordable Care Act (PPACA) | 01/03/2011 | 7021 |
| R344PI | 06/18/2010 | Chapter 10 Manual Redesign - Initial release of Chapter 15 - Rescinded and replaced by Transmittal 347 | 07/05/2011 | 6938 |

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