CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 463	**Date: May 17, 2013**
	Change Request 8117

Transmittal 457, dated April 2, 2013, is being rescinded and replaced by Transmittal 463, dated May 17, 2013, to remove the CMS and contractor logo placement requirements, update the Model Approval Letter to include Add/Terminate Reassignment as another alternative, add the effective date to the Model Approval letter for Ordering and Certifying Providers, add the appeal language to the Model Approval Letter, and to specify that a complete list of all practice locations and NPI/PTAN combinations are only required to be supplied when approving an initial enrollment or revalidation application. Also, the implementation date is being changed to June 7, 2013. All other information remains the same.

SUBJECT: Model Letter Revisions

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise the model letters in Chapter 15 of the Program Integrity Manual and add guidance and example letters.

EFFECTIVE DATE: April 22, 2013
IMPLEMENTATION DATE: June 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/15.8.4/Denials
R	15/15.24/Model Letter Guidance
R	15/15.24.1/ Model Acknowledgement Letter
N	15/15.24.1.1/Acknowledgement Letter Example
R	15/15.24.2/Development Letter Guidance
N	15/15.24.2.1/Model Development Letter
R	15/15.24.3/Model Rejection Letter
R	15.15.24.4/Model Returned Application Letter
R	15/15.24.5/Model Revalidation Letter
R	15/15.24.6/Model Approval Recommended Letter

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.24.7/Approval Letter Guidance
N	15/15.24.7.1/Model Approval Letter
R	15/15.24.8/Denial Letter Guidance
N	15/15.24.8.1/Model Denial Letter
N	15/15.24.8.2/Denial Example #1 - Discipline not eligible
N	15/15.24.8./Denial Example #2 - Criteria for eligible discipline not met
N	15/15.24.8.4/Denial Example #3 - Provider standards not met
N	15/15.24.8.5/Denial Example #4 - Business type not met
R	15/15.24.9/Revocation Letter Guidance
N	15/15.24.9.1/Model Letter - Revocation for Part B Suppliers and Certified Providers and Suppliers
N	15/15.24.9.2/Model Revocation Letter for National Supplier Clearinghouse
N	15/15.24.9./ Revocation Example #1 - Abuse of Billing
N	15/15.24.9.4/Revocation Example #2 - DMEPOS supplier revocation
R	15/15.24.10/Reconsideration Guidance
N	15/15.24.10.1/Model Reconsideration Letter
R	15/15.24.1/Reconsideration Example
R	15/15.24.12/Model Identity Theft Protection Letter
R	15/15.24.13/Identity Theft Prevention Example
R	15.24.14/Model Documentation Request Letter
D	15/15.24.15/Model Revocation Letter for Certified Providers & Suppliers: Revocation Based on an Enrollment Reason(s)
D	15/15.24.16/Model Revocation Letter for Suppliers Furnishing Part B Services
D	15/15.24.17/Model Revocation Letter for OIG Sanctioned Providers/Suppliers
D	15/15.24.18/Model Revocation Letter for National Clearinghouse Supplier (NSC)
D	15/15.24.1/Model Reconsideration Letter
D	15/15.24.20/Model Identify Theft Prevention Letter
D	15/15.24.21/Model Approval Letter - Initial Form CMS 855O Submissions
D	15/15.24.22/Model Rejection Letter - Form CMS-855O Submissions
D	15/15.24.23/Model Denial Letter - Form CMS-855O Submissions
D	15/15.24.24/Model Revocation Letter - Form CMS-855O
R	15/15.27.2/Revocations

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 463	Date: May 17, 2013	Change Request: 8117

Transmittal 457, dated April 2, 2013, is being rescinded and replaced by Transmittal 463, dated May 17, 2013, to remove the CMS and contractor logo placement requirements, update the Model Approval Letter to include Add/Terminate Reassignment as another alternative, add the effective date to the Model Approval letter for Ordering and Certifying Providers, add the appeal language to the Model Approval Letter, and to specify that a complete list of all practice locations and NPI/PTAN combinations are only required to be supplied when approving an initial enrollment or revalidation application. Also, the implementation date is being changed to June 7, 2013. All other information remains the same.

SUBJECT: Model Letter Revisions

EFFECTIVE DATE: April 22, 2013
IMPLEMENTATION DATE: June 7, 2013

I. GENERAL INFORMATION

A. Background: This CR revises the model letters in Chapter 15 of the Program Integrity Manual and adds guidance and example letters.

B. Policy: The purpose of this CR is to issue revised model letters along with guidance for use by the contractors.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8117.1	The contractor shall note the changes to the model letters in section 15.24.	X	X		X	X	X					NSC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Ed Francell, 410-786-1342 or ed.francell@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.463, Issued: 05-17-13)

15.8.4 – Denials

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

A. Denial Reasons

Per 42 CFR §424.530(a), the contractor must deny an enrollment application if any of the situations described below are present, and must provide appeal rights.

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.530(a) (1)) into its determination letter. The contractor shall not use provisions from this chapter 15 as the basis for denial.

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/Regional Office (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.

Primary Denial Reason 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 Medicare enrollment requirements described in this section 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, *that is, there is no statutory or regulatory basis which permits a [Ineligible Discipline, Specialty or Facility*] to enroll or receive payment in the Medicare Program.*

**The following are some ineligible disciplines, specialties, and facilities that may be inserted into the above Specific Denial Reason:*

Acupuncturist

Assisted Living Facility
Birthing Center
Certified Alcohol and Drug Counselor
Certified Social Worker
Chaplains
Drug and Alcohol Rehabilitation Counselor
Hearing Aid Center/Dealer
Licensed Alcoholic and Drug Counselor
Licensed Massage Therapist
Licensed Practical Nurse
Licensed Professional Counselor
Marriage Family Therapist
Master of Social Work[1]
Mental Health Counselor
National Certified Counselor
Occupational Therapist Assistant
Physical Therapist Assistant
Psychoanalyst
Registered Nurse[2]
Speech and Hearing Center
Substance Abuse Facility

[1]*Licensed Clinical Social Workers (LCSWs) are Medicare eligible and almost always have a Master of Social Work degree, however, they must also have at least 2 years or 3000 hours of post Master's degree supervised clinical social work practice. See 42 CFR 410.73.*

[2]*Registered Nurse is a basic requirement for the Medicare eligible specialties of certified registered nurse anesthetists (CRNA); Nurse practitioners (NP); certified nurse-midwives (CNM); and Clinical nurse specialists (CNS), however, these four Advanced Practice Nursing specialties have additional requirements. See 42 CFR 410.69, 42 CFR 410.75, 42 CFR 410.76, and 42 CFR 410.77.*

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. *(This includes situations where, for instance, an owner, partner, managing employee, etc., does not have an SSN/EIN because the individual or entity is foreign.)*

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.

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 that 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.

Primary Denial Reason 42 CFR §424.530(a) (2) ***– Excluded 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.

Primary Denial Reason 42 CFR §424.530(a) (3) ***– Felony Conviction within 10 Years***

The provider, supplier, or any owner of the provider or supplier was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include—

- 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, the contractor shall establish an enrollment bar 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.

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 its Provider Enrollment Operations Group (PEOG) liaison for assistance.

Primary Denial Reason 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 progra*m.*

Primary Denial Reason 42 CFR §424.530(a) (5) – ***On-Site Review – Requirements Not Met***

CMS or its contractor(s) determines, upon on-site review or other reliable evidence, that the provider or supplier is not operational or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is not operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is not operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Primary Denial Reason 42 CFR §424.530(a) (6) ***– Existing Overpayment at Time of Application***

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.

Primary Denial Reason 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.

Primary Denial Reason 42 CFR §424.530(a) (8) ***– Home Health Agency –***

Reserve Operating Funds

A home health agency (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).

Primary Denial Reason 42 CFR §424.530(a) (9) ***– Hardship Exception Denial – 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.)

Primary Denial Reason 42 CFR §424.530(a) (10) ***– Temporary Moratorium on Practice Location***

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.)

B. Denial Letters

1. General

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.

No reenrollment bar shall be established for denied applications. Reenrollment bars apply only to revocations.

2. Prior PEOG Approval

Prior to sending the denial letter, the contractor shall obtain approval of both the denial and the denial letter from its PEOG BFL if the denial involves any of the following situations:

- Situation (d), (e), (g) or (h) under Denial Reason ***42 CFR §424.530(a) (1) – Not in Compliance with Medicare Requirements above.***

- §424.535(a) (2), (a) (3), or (a) (4).

15.24 – *Model Letter Guidance*

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

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 they deem 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: written month/dd/yyyy – Example, January 26, 2012*

Any exceptions to the above must be approved by the contractor's 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, such as removing a CAP section for certain denial and revocation reasons. If there is no guidance for removing a static section, the contractor must obtain approval from their BFL to modify or remove such a section.*

The following do not require 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. Any exceptions to these formats must be approved by the contractor's 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).

15.24.1 – Model Acknowledgement Letter

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

(This letter is optional)

[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] and [is/are] currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

[Additional information if necessary]

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.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

June 27, 2012

Timothy Payne, M.D.
1234 Anywhere Street
Elkhart MT 87321

Reference # (PTAN #, Enrollment #, Case #, 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.

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.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]:

[Contractor name] a Medicare contractor, requires that you complete and submit a Medicare enrollment application(s) and all applicable supporting documentation within 60 calendar days from the postmarked date of this letter per 42 CFR §424.515. Failure to submit complete enrollment application(s) and all supporting documentation within this time frame may result in your Medicare billing privileges being deactivated.

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).*

While an approval of your application(s) will start your 5-year revalidation cycle, you are also required to submit any changes to your enrollment information within specified timeframes pursuant to 42 CFR §424.516. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (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 a Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Please return the complete 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]

15.24.6 – *Model Approval Recommended 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]:

[Contractor name] has assessed your Medicare enrollment application and has forwarded it to [Name of State Office] for review. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). The next step will be a survey or site visit conducted by a State Survey Agency or a CMS approved deemed accrediting organization to ensure compliance with required Conditions of Participation. Once the CMS Regional Office confirms that these conditions 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]

15.24.7 – Approval Letter Guidance

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

- *Depending on the type of approval, one of the following shall be selected for insertion in the first sentence:*

[Initial Medicare enrollment application]
[Revalidated Medicare enrollment application]
[Change of information request]
[Add/Terminate a Reassignment of Benefits request]

- *If provider/supplier is NOT exclusively ordering or certifying, REMOVE the following sentence:*

  This application is for the sole purpose of ordering or certifying items or services for Medicare beneficiaries to other providers and suppliers.

- *Ordering or Certifying Providers*

  The last two sentences of the 1st paragraph shall be the following:

  Listed below is your National Provider Identifier (NPI). To start billing, you must use your NPI on all Medicare claim submissions.

  REMOVE paragraph 2 and paragraph 3, which refer to PTAN usage.

  If provider/supplier IS exclusively ordering or certifying, REMOVE the following three fields:

  Practice location: [Address]
  Provider Transaction Access Number (PTAN): [PTAN]
  You are a: [participating]/[non-participating]

  The effective date field shall remain in the letter and reflect the date on which the contractor received the signed paper CMS-855O form or the Web-based certification statement/e-signature.

  Effective date: [Effective date or Termination date of Ordering or Certifying Status]

- *Revalidated and Change of Ownership (CHOW) Approvals*

  For revalidated and Change of Ownership (CHOW) approvals, paragraphs #2 and #3 of the letter are optional.

  - *If letter is NOT approving a Change of Ownership (CHOW), REMOVE the following field:*

Medicare Year End Cost Report Date: [Date]

- *On the effective date field, if voluntarily terminating Medicare participation, insert "of termination" after "Effective date"*

- *Physicians, certain non-physician practitioners, and physician and non-physician practitioner organizations may appeal their effective date made by the contractor (JSM/TDL-11023)*

- *Supply additional "Medicare Enrollment Information" for each additional location and NPI/PTAN combination) only when approving an Initial or Revalidation application. If multiple locations and NPI/PTAN combinations exist, a separate document identifying this information shall be attached to the approval letter.*

- *Changes of information submitted to report a change to a data element other than those listed as one of the predefined elements, shall be added to the predefined list under the Medicare Enrollment Information section to acknowledge the change has been incorporated.*

- *The 2nd,3rd and 4th paragraphs may be edited or deleted in appropriate circumstances:*

  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].

- *Under "Medicare Enrollment Information, for group member enrollment, the following fields may be added:*

  Group National Provider Identifier (NPI): [NPI]

Group Provider Transaction Access Number (PTAN): [PTAN]

15.24.*7.1 – Model Approval 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 are pleased to inform you that your [initial Medicare enrollment application]/[revalidated Medicare enrollment application]/[change of information request] is approved. This application is for the sole purpose of ordering and referring items or services for Medicare beneficiaries to other providers and suppliers. 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]*
Practice location:	*[Address]*
National Provider Identifier (NPI):	*[NPI]*
Provider Transaction Access Number (PTAN):	*[PTAN]*
Specialty:	*[Provider specialty]*
You are a:	*[participating]/[non-participating]*
Effective date:	*[Effective date or Effective date of termination]*
Medicare Year-End Cost Report date:	*[Date]*

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 CFR §424.516. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (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, or a Medicare revocation by a different Medicare contractor.

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). Go to: www.cms.hhs.gov/MedicareProviderSupEnroll.

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] or the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/home/medicare.asp.

If you disagree with the effective date determination in this letter, 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 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 the 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 the physician, non-physician practitioner or any responsible 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:

[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]

15.24.8 – *Denial Letter Guidance*

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

- *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 and DMEPOS 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.

15.24.8.1 – Model Denial 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 application to enroll in Medicare is denied for the following reason(s):

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

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:

[Name of MAC]
[Address]
[City], ST [Zip]

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:

[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]

15.24.8.2 –Denial Example #1 – Discipline not eligible

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

June 5, 2012

Xantippe Jones, LMFT
7824 Freudian Way
Yakima, WA 94054

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear Mr. Jones:

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

There is no statutory or regulatory basis which permits a Marriage and Family Therapist to enroll or receive payment in the Medicare Program.

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. 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.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

June 7, 2012

Marjorie Gosling, NP
6578 Billings Avenue
Calgary, MI 42897

Reference # (PTAN #, Enrollment #, Case #, etc.)

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 recognizednational 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. 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.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

June 1, 2012

IDTF Services, Inc.
2498 Blood Draw Way
Eagle Rock, Arizona 98001

Reference # (PTAN #, Enrollment #, Case #, etc.)

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. 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.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

June 5, 2012

Roger Bain, M.S. CCC-SLP
6092 Wisconsin Way
Royal, MN 59034

Reference # (PTAN #, Enrollment #, Case #, etc.)

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. 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.

15.24.9 – *Revocation Letter Guidance*

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

- *The contractor must submit one or more of the 12 Primary Revocation Reasons as found in x.x.x into the appropriate section on the specific Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason.*

- *The contractor may submit a Specific Revocation Reason, as appropriate. The Specific Revocation Reason should state sufficient details so it is clear as to why the provider or supplier is being denied.*

- *Specific Revocation Reasons may contain a combination of the following items:*

    - *A specific regulatory (CFR) citation.*

    - *Dates (of actions, suspensions, convictions, receipt of documents, etc.)*

    - *Actions*

- *Exclusions and sanctions – the following two sentences should be REMOVED for all revocation 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.

- *Corrective Action Plan language – For revocation reasons #2 (42 CFR §424.535(a) (2), #3 (42 CFR §424.535(a) (3), and #5 (42 CFR §424.535(a) (5), the provider or supplier shall not be given the option of submitting a corrective action plan. Therefore, the following language must be REMOVED from the letter:*

  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:

  (Organization)
  (Address)
  (City), ST (Zip)

  - *Certified Providers and Suppliers language*

    - *If the provider is NOT CERTIFIED the following adjustments need to be made on the letter.*

      The following sentence needs to be removed:

      Pursuant to 42 CFR §424.545(a), this action will also terminate your corresponding provider agreement.

      The Corrective Action Plan (CAP) must be sent to the Contractor's address.

    - *If the provider is CERTIFIED, the following adjustments need to be made on the letter.*

The Corrective Action Plan must be sent to CMS at the following address:

Centers for Medicare and Medicaid Services
Provider Enrollment Operations Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore MD 21244-1850

- *National Supplier Clearinghouse - Revocation Letters - adjustments*

  - *If a response to the developmental letter was submitted, insert the following section:*

    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 durable medical equipment, prosthetics & orthotics standards (DMEPOS) supplier standards and/or to correct the deficient compliance requirement(s).

  - *If a response to the developmental letter was NOT submitted, insert the following section:*

    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 durable medical equipment, prosthetics & orthotics standards (DMEPOS) supplier standards and/or to correct the deficient compliance requirement(s)

  - *If a fee payment was NOT paid in response to a developmental letter denying a hardship exception (42 CFR §424.535(a) (6)), insert the following section:*

    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.

- *If a fee payment was NOT paid in response to a developmental letter notifying the provider or supplier that the application fee was not paid at the time of initial application, (42 CFR §424.535(a)(6)), insert the following section:*

  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 30 day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application.

- *Final Adverse Action - language*

  - *If a contractor determines that a Final Adverse Action has NOT occurred, the following section should be removed:*

    Finally, in accordance with 42 CFR §424.565, [Contractor name] is assessing an overpayment in the amount of [insert dollar amount] because the physician or non-physician practitioner continued to furnish services to Medicare beneficiaries after a final adverse action precluded enrollment in the Medicare program.

  - *Note: As stated in 42 CFR §424.565, Medicare contractors should assess an overpayment back to January 1, 2009, not the date of the final adverse action if the adverse action occurred prior to January 1, 2009.*

- *For IDTF and DMEPOS 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© 1 through 30.*

See 42 CFR 424.535 to view the circumstances that warrant a fee-for-service contractor to revoke a provider or supplier's Medicare billing privileges. If the certified provider or certified supplier (i.e., ambulatory surgery center (ASC) and portable x-ray) is revoked based on a condition of participation, then the applicant or enrolled entity must submit a reconsideration or corrective action plan with CMS

15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers

(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 privileges are being revoked effective [Date of revocation] for the following reasons: Pursuant to 42 CFR §424.545(a), this action will also terminate your corresponding provider agreement.

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

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:

[Name of MAC] *[Address]* *[City], ST [Zip]*	*or*	*[Centers for Medicare & Medicaid Services]* *[Provider Enrollment Operations 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 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:

[Name of MAC]
[Address]
[City], ST [Zip]

Pursuant to 42 CFR §424.535(c), [Contractor name] is establishing a re-enrollment bar for a period of [Insert amount of time]. 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 [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.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.)

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 [xxxxxxxxxx] 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 30 day 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.

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 NSC, with Centers for Medicare & Medicaid Services (CMS) approval, may reinstate your supplier number after it reviews your CAP and any additional evidence you submit and determines you are now in compliance with all supplier standards (see 42 CFR §424.57(c)). CAP requests should be sent to:

[National Supplier Clearinghouse Contractor name]
[Address]
[City], ST [Zip]

If you believe that this determination is not correct, you may request 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 reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

[National Supplier Clearinghouse Contractor name]
[Address]
[City], ST [Zip]

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 [number of years] 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.

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.

If you have any questions, please contact our customer service number at [phone number].

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

15.24.10 – *Reconsideration Guidance*

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

If the reconsideration is for an earlier Effective Date, the following language may be substituted for the existing paragraph beginning with "DECISION:":

DECISION: [Provider/Supplier Name][has/had not] provided evidence to definitely support an earlier effective date. Therefore, we [grant/cannot grant]

you access to the Medicare Trust Fund (by way or issuance) of a new effective date.

15.24.10.*1 – Model Reconsideration 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]:

This letter is in response to your reconsideration request received by [Contractor name] in response to a [revocation/denial/effective date]. The initial determination letter was dated [Date] so the appeal was timely submitted. The following decision is based on the Social Security Act, Medicare regulations, The Center for Medicare and Medicaid Services (CMS) manual instructions, evidence in the file, and any information you may have submitted since the time of your request.

Revocation, Denial, or Effective date reason: [xx CFR §xxx.(x)]

[specific reason]

Revocation, Denial, or Effective date reason: [xx CFR §xxx.(x)]

[specific reason]

SUMMARY OF SUBMITTED DOCUMENTATION: [Insert all documentation/supporting information submitted].

EVALUATION OF SUBMITTED DOCUMENTATION: [Insert evaluation of documentation/supporting information].

DECISION: [Provider/Supplier Name] [has/had not] provided evidence to show full compliance with the standards for which you were [revoked/denied]. Therefore, we [grant/cannot grant] you access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

This decision is a(n) [FAVORABLE/UNFAVORABLE] DECISION. Please see below for additional appeal rights.

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 a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201
Attn: CMS Enrollment Appeal

The following information is required with all ALJ 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.*

Alternatively, 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 is a party or authorized representative. Once registered, you may file your appeal by:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, 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.*

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed

request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). 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 Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. 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.

Appeal rights can be found at 42 CFR §498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities [meet/continue to meet] the requirements for enrollment in the Medicare program.

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.*24.11 –Reconsideration Example*

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

February 18th, 2012

Biff McSwain, M.D.
c/o Apple-A-Day Medical Services, Inc.
Anywhere, TX 70043

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear Apple-A-Day Medical Services/Biff McSwain, M.D.:

This letter is in response to your reconsideration request received by Medicare Administrative Contractor Inc. in response to a revocation. The initial determination letter was dated September 14, 2011 so the appeal was timely submitted. The following decision is based on the Social Security Act, Medicare regulations, The Center for Medicare and Medicaid Services (CMS) manual

instructions, evidence in the file, and any information you may have submitted since the time of your request.

Revocation or Denial reason: 42 CFR §424.530(a)(1)

Specifically, on October 13, 2011 Medicare Administrative Contractor Inc. revoked your billing privileges effective September 14, 2011. In addition a 1 year enrollment bar was imposed.

At the time of your revocation, you did not have a license, or were not authorized by the Federal/State/local government to perform the services for which you intended to render in accordance with 42 §CFR 410.20(b). The suspension of your license was issued on September 14, 2011. Therefore you were determined not to be in compliance with the enrollment requirements.

SUMMARY OF SUBMITTED DOCUMENTATION: On March 12, 2012, Medicare Administrative Contractor, Inc. received an 855I application to re-enroll Biff McSwain MD.

EVALUATION OF SUBMITTED DOCUMENTATION: Medicare Administrative Contractor Inc. is unable to process the submitted enrollment application because Biff McSwain MD has not exceeded the re-enrollment bar period. Per 42 CFR §424.535(c)(1), after a provider, supplier, delegated official, or authorizing official has had its billing privileges revoked, it is 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 is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation.

DECISION: Biff McSwain MD has not provided evidence to show full compliance with the standards for which he was revoked. Therefore, we cannot grant you access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

This decision is an UNFAVORABLE DECISION. Please see below for additional appeal rights.

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 a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.

Cohen Building, Room G-644
Washington, D.C. 20201
Attn: CMS Enrollment Appeal

The following information is required with all ALJ 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*

Alternatively, 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 is a party or authorized representative. Once registered, you may file your appeal by:

- *Clicking the File New Appeal link on the Manage Existing Appeals screen, 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.*

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). 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 Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. 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.

Appeal rights can be found at 42 CFR §498. The regulation explains the appeal rights following the determination by the CMS as to whether such entities continue to meet the requirements for enrollment in the Medicare program.

If you have any questions, please contact our office at 312-555-1212 between the hours of 8:00 AM and 5:00 PM EST.

Sincerely,

Muffy McGuire
Revalidation Specialist
Medicare Administrative Contractor Inc.

15.24.1*2 – 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.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]:

[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.]

Consistent with § 424.516(f) [(x)], 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]

15.27.2 – Revocations

(Rev.463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)

A. Revocation Reasons

The contractor may issue a revocation using revocation reasons 1-7 and 9-13 below without prior approval from CMS. Sections 15.27.3 through 15.27.3.2 below address revocation reason 8 (42 CFR §424.535(a) (8)), which requires review and approval by the Provider Enrollment Operations Group (PEOG).

When issuing a revocation, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a) (1)) into its determination letter. The contractor shall not use provisions from this chapter as the basis for revocation.

Primary Revocation Reason 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 described in this section 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.

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 the contractor shall use §424.535(a) (1) 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 *, that is, there is no statutory or regulatory basis which permits a [Ineligible Discipline, Specialty or Facility*] to enroll or receive payment in the Medicare Program.*

**The following are some ineligible disciplines, specialties, and facilities that may be inserted into the above Specific Revocation Reason:*

Acupuncturist
Assisted Living Facility
Birthing Center
Certified Alcohol and Drug Counselor
Certified Social Worker
Drug and Alcohol Rehabilitation Counselor
Hearing Aid Center/Dealer
Licensed Alcoholic and Drug Counselor
Licensed Massage Therapist
Licensed Practical Nurse
Licensed Professional Counselor
Marriage Family Therapist
Master of Social Work[1]
Mental Health Counselor
National Certified Counselor
Occupational Therapist Assistant
Physical Therapist Assistant
Psychoanalyst

Registered Nurse[2]
Speech and Hearing Center
Substance Abuse Facility

[1]*Licensed Clinical Social Workers (LCSWs) are Medicare eligible and almost always have a Master of Social Work degree, however, they must also have at least 2 years or 3000 hours of post Master's degree supervised clinical social work practice. See 42 CFR 410.73.*

[2]*Registered Nurse is a basic requirement for the Medicare eligible specialties of certified registered nurse anesthetists (CRNA); Nurse practitioners (NP); certified nurse-midwives (CNM); and Clinical nurse specialists (CNS), however, these four Advanced Practice Nursing specialties have additional requirements. See 42 CFR 410.69, 42 CFR 410.75, 42 CFR 410.76, and 42 CFR 410.77.*

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. *(This includes situations where, for instance, an owner, partner, managing employee, etc., does not have an SSN/EIN because the individual or entity is foreign.)*

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. *(Note that this revocation reason should 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.

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 that 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.

Primary Revocation Reason 42 CFR §424.535(a) (2) ***– Excluded 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 Provider Enrollment Operations Group (PEOG) liaison immediately. PEOG will notify the Government Task Leader (GTL) for the appropriate Zone Program Integrity Contractor. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

Primary Revocation Reason 42 CFR §424.535(a)(3) ***– Felony Conviction within 10 Years.***

The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.

(i) Offenses include—

(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.*

Primary Revocation Reason 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.)

Prior to revoking a provider or supplier's Medicare billing privileges pursuant to §424.535(a) (4), the contractor shall contact its PEOG liaison for guidance.

Primary Revocation Reason 42 CFR §424.535(a) (5) ***– On-site Review – Requirements Not Met***

The CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Primary Revocation Reason 42 CFR§424.535(a) (6) **– *Application Fee or Hardship Exception Request not Submitted***

(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.

Primary Revocation Reason 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.

Primary Revocation Reason 42 CFR §424.535(a) (8) **– *Abuse of Billing Privileges***

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.

Please see sections 15.27.3 through 15.27.3.2 of this chapter for instructions regarding the use of this revocation reason.

Primary Revocation Reason 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.

Note the following with respect to Revocation 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 revoke the supplier's billing privileges 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 revoke the supplier's billing privileges.

Primary Revocation Reason 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 § 424.516(f).

Primary Revocation Reason 42 CFR §424.535(a) (11) ***– Home Health Agency – Reserve Operating Funds***

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).

Primary Revocation Reason 42 CFR §424.535(a) (12) **– *Medicaid Privileges Revoked***

The provider or supplier's Medicaid billing privileges are terminated or revoked by a State Medicaid Agency.

(Note that 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).

See subsection F below for information on a revocation's effect on the provider's other Medicare enrollments.