# Medicare Program Integrity Manual
## Chapter 15 - Medicare Enrollment

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## 15.1 – Introduction to Provider Enrollment
**(Rev. 347, Issued: 07-15-10, Effective: 07-30-10, Implementation: 07-30-10))**

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

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

## 15.1.2 – Medicare Enrollment Application (Form CMS-855)
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

Providers and suppliers, including physicians, may enroll or update their Medicare enrollment record using the:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or

- Paper enrollment application process (e.g., Form CMS-855I).

The Medicare enrollment applications are issued by CMS and approved by the Office of Management and Budget.

The five enrollment applications are distinguished as follows:

- CMS-855I - This application should be completed by physicians and non-physician practitioners who render Medicare Part B services to beneficiaries. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity.)

- CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The individual must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

- CMS-855B - This application should be completed by supplier organizations (e.g., ambulance companies) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

- CMS-855A - This application should be completed by institutional providers (e.g., hospitals) that will furnish Medicare Part A services to beneficiaries.

- CMS-855S – This application should be completed by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The National Supplier Clearinghouse (NSC) is responsible for processing this type of enrollment application.

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

A separate application must be submitted for each provider/supplier type.

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855, the contractor shall encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:

- The CMS Web site at which information on Internet-based PECOS can be found and at which the paper applications can be accessed (www.cms.hhs.gov/MedicareProviderSupEnroll).

- Any supporting documentation required for the applicant's provider/supplier type.

- Other required forms, including:

  - The Electronic Funds Transfer Authorization Agreement (Form CMS-588) (Note: The NSC is only required to collect the Form CMS-588 with initial enrollment applications.)

  - The Electronic Data Interchange agreement (Note: This does not apply to the NSC.)

  - The Medicare Participating Physician or Supplier Agreement (Form CMS-460). The contractor shall explain to the provider or supplier the purpose of the agreement and how it differs from the actual enrollment process. (This only applies to suppliers that complete the Forms CMS-855B and CMS-855I.)

- The contractor's address so that the applicant knows where to return the completed application.

- If the applicant is a certified supplier or certified provider, the need to contact the State agency for any State-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities, such as federally qualified health centers, that do not receive a State survey.) The notification can be given in any manner the contractor chooses.

## 15.2 – Provider and Supplier Business Structures

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

This section explains the legalities of various types of business organizations that may enroll, including sole proprietorships. Note that the provider's organizational structure can have a significant impact on the type of information it must furnish on the Form CMS-855 or CMS-

20134.

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

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

**A. Sole Proprietorships**

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

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

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

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

**B. Partnerships**

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

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

- Each partner is liable for all the debts of the partnership. Using the example above, suppose the Y Partnership breached a contract it had with X, who now sues for $10,000. Since each partner is liable for all debts, X can collect the entire $10,000 from A, or from B, or $5,000 from each, etc. This is because, unlike a corporation, a partnership is not really a separate and distinct entity from its partners/owners; the partners are the partnership. If Y had been a corporation, the owners (A and B) would likely have been shielded from liability.

- There is no "double taxation" with partnerships. The partnership itself does not pay taxes, although each partner pays taxes on any income he/she earns from the business.

- Unlike a corporation, a partnership generally does not file papers with the State upon its creation (i.e., it does not file the equivalent of articles of incorporation). Instead, a partnership has a "partnership agreement," which amounts to a contract between the partners outlining duties, responsibilities, powers, etc.

- Each partner has the right to participate in running the business's day-to-day operations, unless the partnership agreement dictates otherwise.

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

**C. Limited Liability Companies (LLC)**

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

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

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

**D. Joint Ventures**

A joint venture is when two or more persons/entities combine efforts in a business enterprise and

agree to share profits and losses. It is very similar to a partnership, and is treated as a partnership for tax purposes. The key difference is that a partnership is an ongoing business, while a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, can be classified as a "temporary partnership."

**E. Corporations**

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

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

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

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

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

Two special types of corporations that contractors may encounter are:

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

- "Close" Corporation (or "closely-held" corporation) – This is a type of corporation with a very limited number of stockholders. Unlike a "regular" corporation, the entity's board of directors generally does not run the business; rather, the shareholders do. The stock is typically not sold to outsiders.

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

### F. Non-Profit Organizations

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

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

### G. Government-Owned Entities

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

Note that:

- GOEs do not have "owners." Thus, section 5 of the Form CMS-855 or CMS-20134 need only contain the name of the government body in question. Using our example above, this would be Smith County.

- For section 6 of the Form CMS-855 or CMS-20134, the only people that must be listed are "managing employees." This is because GOEs do not have corporate officers or directors.

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

## 15.3 – National Provider Identifier (NPI)

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

### A. Submission of NPI

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the

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

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

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

## B. Additional NPI Information

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

## C. Subparts - General

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

CMS encourages all providers to obtain NPIs in a manner similar to how they receive CMS Certification Numbers (CCNs) (i.e., a "one-to-one relationship"). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider

and the branch will typically receive separate (albeit very similar) CCNs. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each CCN.

**D. Medicare Subparts Paper - Text**

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

### Purpose of this Paper

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

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

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

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

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

This paper is not intended to serve as official HHS guidance to the industry in determining subparts for any covered health care providers other than those that are organizations and are

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

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

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

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

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

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

- A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)

- A subpart furnishes health care as defined at 45 CFR § 160.103.

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

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

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

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

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

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

## Medicare Statutes, Regulations, Manuals

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

## Medicare Organization Providers and Subparts: Certified Providers and Certified Suppliers

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

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

**Certified Providers that bill Medicare Part A (hereinafter referred to as "providers"):**

- Providers apply for Medicare enrollment by completing a Form CMS-855A.

- Most providers are surveyed and certified by the States[3] prior to being approved as Medicare providers.

- Providers have in effect an agreement to participate in Medicare.[4]

- Providers include, but are not limited to: skilled nursing facilities, hospitals[5], critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.

- Providers are assigned CCNs to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.

- In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (One exception involves home health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

**Certified Suppliers, which bill Medicare Part B:**

- Certified suppliers apply for Medicare enrollment by completing a Form CMS-855A or CMS-855B, depending on the supplier type.

- Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.

- Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)

- Certified suppliers may have in effect an agreement to participate in Medicare.

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3 Religious non-medical health care institutions are handled differently.
4 Community mental health centers attest to such an agreement. Religious non-medical health care institutions are handled differently.
5 Hospitals bill Medicare Part B for certain types of services.

- Certified suppliers are assigned CCNs for purposes of identification within Medicare processes. However, the contractors assign unique identification numbers to certain certified suppliers for billing purposes. (For CLIA labs, a CLIA number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA number may not be used to identify a clinical laboratory as a "health care provider" in HIPAA standard transactions. The CLIA number has no relation to the Medicare PTAN.)

- In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

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

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

- Obtain its own unique NPI.

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

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

## Medicare Organization Providers and Subparts: Supplier Groups and Supplier Organizations

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

- Supplier groups and supplier organizations apply for Medicare enrollment by completing a Form CMS-855B or CMS-20134.

- Supplier groups and supplier organizations bill Medicare Part B.

- Certain supplier organizations are certified by the States, certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the contractor. These requirements vary by type of supplier organization.

- Supplier groups are primarily group practices, such as a group of physicians or other practitioners.

    - Supplier organizations include ambulance companies, mammography facilities, and independent diagnostic testing facilities (IDTFs) and Medicare Diabetes Prevention Program (MDPP) suppliers.

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

1. When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a Form CMS-855B and the IDTF would complete a Form CMS-855B. Each one would receive its own unique Medicare identification number.

2. If a separate site visit, State certification, or on-site inspection by the contractor or if FDA certification is required for each practice location of that supplier group/supplier organization.

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

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

- Obtain its own unique NPI.

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

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

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

## Medicare Organization Providers and Subparts: DMEPOS Suppliers

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

- A supplier of DMEPOS enrolls in Medicare through the National Supplier Clearinghouse (NSC) by completing a Form CMS-855S.

- Suppliers of DMEPOS bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

- Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies. (Any organization that sells equipment or supplies that are billed to Medicare through the DME MAC must be enrolled as a supplier of DMEPOS through the NSC. Sometimes, these are organizations that also furnish services that are covered by Medicare, such as ambulatory surgical centers. In order to be reimbursed for the DME supplies that they sell, they must separately enroll in Medicare as a supplier of DME.)

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

## Final Notes About NPIs

**Enrolled organization health care providers or subparts that bill more than one Medicare contractor:** An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor. For example, a physician group practice billing Contractor X and also billing Contractor Y would use a single (the same)

NPI to bill both contractors.

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

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

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

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

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

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

## 15.3.1 – NPI-Legacy Combinations

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

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

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

## 15.3.2 – NPI Punctuation

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

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

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

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

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

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

| | | |
|---|---|---|
| | | should refer to the IRS CP-575. If the LBN 'Rehab and Health, Inc.' is displayed on the IRS CP-575, the contractor may accept the match. If 'Rehabilitation and Health, Inc.' is present, the contractor should ask the provider to correct its NPPES information. The provider must change its LBN in NPPES to read in accordance with the IRS CP-575. |

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

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

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

### A. Background

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

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

### B. Precedence of Sections 15.7 through 15.7.1.6.2

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

See sections 15.7.1.3.1 and 15.7.1.3.2 for information regarding "processing alternatives."

## 15.5.1 - Basic Information (Section 1 of the Form CMS-855 and CMS-20134)

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

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

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

- Seeking to reestablish itself in the Medicare program after reinstatement from an exclusion or debarment or after the expiration of a reenrollment bar, or

- A hospital requesting enrollment via the Form CMS-855B to bill for practitioner services for hospital departments, outpatient locations and/or hospital clinics.

- A hospital, clinic or other entity with an existing enrollment in Medicare requesting enrollment as an MDPP supplier via the Form CMS-20134 to bill for MDPP services.

## 15.5.2 – Identifying Information (Section 2 of the Form CMS-855 and Form CMS-20134)

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

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

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

## 15.5.2.1 – Licenses and Certifications, and Recognition

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

The extent to which the applicant must complete the licensure or certification information in section 2 of the Form CMS-855 depends upon the provider type involved. For instance, some states may require a particular provider to be “certified” but not “licensed,” or vice versa. Additionally, applicants applying through the Form CMS-20134 are not required to have either a license or certification, but rather CDC recognition, described further in this section (see 15.5.2.1.C).

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

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

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

- The state where the supplier is enrolling.

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

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

The contractor shall also adhere to the following:

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

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

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

- **Notarization:** If the applicant submits a license that is not notarized or "certified true," the contractor shall verify the license with the appropriate state agency. (A notarized copy of an original document has a stamp that says "official seal," along with the name of the notary public, the state, the county, and the date the notary's commission expires. A certified "true copy" of an original document has a raised seal that identifies the state and county in which it originated or is stored.)

- **Temporary Licenses:** If the supplier submits a temporary license, the contractor shall note the expiration date in PECOS. Should the supplier fail to submit the permanent license after the temporary license expiration date, the contractor shall initiate revocation procedures. (A temporary permit – one in which the applicant is not yet fully licensed and must complete a specified number of hours of practice in order to obtain the license – is not acceptable.)

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

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

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

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

**B. Form CMS-855A**

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

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

**C. Form CMS-20134**

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

## 15.5.2.2 – Correspondence Address and E-mail Addresses

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

**A. Correspondence Address**

The contractor may accept a particular correspondence address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to

verify the correspondence address. It cannot be the address of a billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

**B. Correspondence Telephone Number**

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

**C. Email Addresses**

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

**D. Contact Persons**

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

## 15.5.2.3 – Accreditation

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

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

## 15.5.2.5 – Section 2 of the Form CMS-855B

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

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

- If the group indicates that it renders services in patients' homes, the contractor shall verify that the group has an established private practice where it can be contacted directly and where it maintains patients' records.

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

## 15.5.2.6 – Section 2 of the Form CMS-855I

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

### A. Specialties

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

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

### B. Education for Non-Physician Practitioners

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

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

### C. Resident/Intern Status

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

The physician should indicate the exact date that its residency program, internship, or fellowship

was completed, so that the appropriate effective date can be issued.

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

**D. Physician Assistants**

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

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

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

**E. Psychologists Billing Independently**

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

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

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

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

If the individual answers "yes" to question 2, 3, 4, or 5, the contractor shall request a copy of the lease agreement giving him/her exclusive use of the facilities for PT/OT services only if it has

reason to question the accuracy of his/her response. If the contractor makes this request and the provider cannot furnish a copy of the lease, the contractor shall deny the application.

## 15.5.2.7 – Section 2 of the CMS-20134

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

### A. Type of Supplier

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

### B. CDC DPRP Recognition

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

- MDPP Preliminary recognition or
- CDC DPRP Full Recognition

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

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

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

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

### C. Correspondence Address and Email Address

Refer to processing steps outlined in 15.5.2.2.

## 15.5.3 – Final Adverse Actions

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

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

### A. Disclosure of Final Adverse Action

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

In addition:

1. Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the OIG or, in the case of debarment, through the federal agency that took the action. The contractor shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).

2. Scope of Disclosure – All final adverse actions that occurred under the LBN and TIN of the disclosing entity (e.g., applicant; section 5 owner) must be reported.

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

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

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

ASC in a fifth State. Y must disclose its felony conviction even though the felony conviction occurred in a state different from that in which the ASC is located.

3. Timeframe – With the exception of felony and misdemeanor convictions all other final adverse actions must be reported in the final adverse legal action of the Form CMS-855 or Form CMS-20134, all final adverse actions must be reported regardless of when the final adverse legal action occurred.

4. Evidence to Indicate Final Adverse Action – There may be instances where the provider or supplier states on Form-855 or Form CMS-20134 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall follow the decision tree in section 15.5.3.1.

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

**B. Reportable Final Adverse Actions**

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

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

1. Felony conviction(s) within 10 years

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

2. Misdemeanor Conviction Within 10 years
    - Report a misdemeanor conviction (Federal or State ) when—

- A conviction has occurred; and
- The misdemeanor judgment (disposition) date is within 10 years, from the submission date of an Form CMS-855 or Form CMS-20134 application, and
- The misdemeanor is related to:
    - The delivery of an item/service under Medicare or a State health care item/service
    - The abuse or neglect of a patient in connection with the delivery of a health care item or service
    - Theft, Fraud, Embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health care item/service
    - The interference with or obstruction of any investigation into any criminal offense
    - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance

- A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.
- A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

3. Current or Past Suspension(s)/Revocations(s) of a medical license

    - A medical license board suspends or revokes a medical license for any period of time.

4. Current or Past Suspensions(s)/Revocation(s) of an accreditation

    - An accrediting body suspends or revokes an accreditation for any period of time.

5. Current or Past Suspension(s) or Exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)

    - Items/services furnished, ordered or prescribed by a specified individual/entity are not reimbursed under Medicare, Medicaid and/or all other Federal health care programs until the individual or entity is reinstated by the HHS OIG.

6. Current or Past Debarment(s) from participation in any Federal Executive Branch procurement or non-procurement program

- An individual or entity is suspended throughout the Executive Branch or the Federal government, as it applies to procurement and non-procurement programs. An individual or entity will not be solicited from, contracts will not be awarded to or existing contracts will not be renewed or otherwise extended to those individuals or entities with a debarment. (e.g. GSA debarment)

7. Medicaid exclusion(s), revocation(s) or termination(s) of any billing number

    - A state terminates an active provider agreement or prohibits a provider from enrolling in the Medicaid program.

8. Any other Current or Past Federal Sanction(s)
    - A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP), Corporate Integrity Agreement (CIA)).

**C. Prior Approval**

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

**D. Review of PECOS**

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

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

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

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

**F. System for Award Management (SAM)**

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

that are debarred as well, such as “John Smith Company,” “Smith Consulting,” “Jane Smith,” and “Joe Smith.”

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

## 15.5.3.1 – Reviewing for Adverse Legal Actions

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

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

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

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

## I. INITIAL/ REACTIVATION APPLICATIONS

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

### 1.1 LICENSURE – INITIAL/REACTIVATION APPLICATIONS

| **Provider holds a valid accreditation/medical license in the state in which they are enrolling** | **Did the provider report the ALA taken on their license/ accreditation?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Provider's accreditation/medical license was previously suspended / revoked / voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.2 – 1.8. | MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/revocation. e.g. Felonies. |
| Provider's accreditation/medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | No | Deny application under 42 CFR § 424.530 (a)(4) unless the license adverse action occurred more than ten years prior to the date of application receipt. If a license suspension/revocation /surrender in lieu of disciplinary proceedings occurred more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision. | 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action.<br><br>MACs shall consider whether other denial reasons exist. Refer to section (s) 1.2 – 1.8.<br><br>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/ revocation. e.g. Felonies<br><br>No Reporting Requirement:<br><br>• A suspension is "stayed" in its entirety.<br><br>• Advertising/Administrative penalties<br><br>• Fines, Violations, Stipulations, Reprimands |

| 1.2 FELONIES – INITIAL/REACTIVATION APPLICATIONS | | | |
|---|---|---|---|
| **Felony** | **Did the provider report their felony?** | **MAC Action** | **Notes** |
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a felony and/or a crime that is punishable by imprisonment. for a period of one year or more | Yes or No | Send application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | All felony convictions shall be forwarded to CMS for review and decision. |

| 1.2 MISDEMEANORS – INITIAL/REACTIVATION APPLICATIONS | | | |
|---|---|---|---|
| **Misdemeanor** | **Did the provider report their misdemeanor?** | **MAC Action** | **Notes** |
| Provider or someone with ownership interest and/or managing control has been adjudged guilty of a misdemeanor that is related to healthcare. abuse or patient, financial misconduct, interference with a criminal investigation, or un-lawful manufacture, distribution, prescription or dispensing of a controlled substance. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 & 1.3 – 1. 8. | |
| Provider or someone with ownership interest and/or managing control has been of a misdemeanor that is related to healthcare, abuse or neglect of a patient, financial misconduct, interference with a criminal investigation, or un-lawful manufacture, distribution, prescription or dispensing of a controlled substance. | No | Send ALA information to EnrollmentReview@cms.hhs.gov for review and decision. | |

| 1.3 EXCLUSION (ACTIVE) – INITIAL/REACTIVATION APPLICATIONS | | | |
|---|---|---|---|
| **Current Exclusion** | **Did the provider report their current exclusion?** | **MAC Action** | **Notes** |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | Yes | Deny application under 42 CFR § 424.530 (a)(2) | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.2 & 1.4 - 1.8.<br><br>A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to Enroll-mentReview@cms.hhs.gov for review. |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | No | Deny application under 42 CFR § 424.530 (a)(2) & (a)(4) | 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action. However § 424.530 (a)(2), in this particular scenario, would still be apply. |

## 1.4 EXCLUSION (EXPIRED) – INITIAL/REACTIVATION APPLICATIONS

| **Exclusion period has expired** | **Did the provider report their past exclusion?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Provider or someone with ownership interest and/or managing control has a HHS and/or OIG exclusion has been reinstated by HHS and/or OIG. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.3 & 1.5 – 1. 8. | |
| Provider or someone with ownership interest and/or managing control has a and/or OIG exclusion that has expired and has been reinstated by HHS and/or OIG. | No | Deny application under 42 CFR § 424.530 (a)(4) unless the provider was reinstated more than ten years prior to the date application receipt. If a provider has been reinstated more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision. | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.3 & 1.5 – 1.8.<br><br>42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse |

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

| **Medicare Payment Suspension is currently active** | **Did the provider report their current Medicare Payment Suspension?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Current Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.4 & 1.6-1. 8 | Providers are NOT required to report Current or Past Medicare Payment Suspensions to CMS.<br><br>MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.4 & 1.6 – 1.7, 1.8. |

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

| **Medicare Payment Suspension that is NOT currently active** | **Did the provider report their past Medicare Payment Suspension?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Past Medicare Payment Suspension | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.5 & 1. 8. | Providers are NOT required to report Current or Past Medicare Payment Suspensions to CMS.<br><br>MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.5 & 1.7, 1.8. |

## 1.7 MEDICARE REVOCATION – INITIAL/REACTIVATION APPLICATIONS

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

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

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

## II. REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS

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

## 2.1 LICENSURE – REVALIDATIONS/ CHANGE OF INFORMATION APPLICATIONS

| **Provider holds a valid accreditation/medical license in the state in which they are revalidating or changing information** | **Did the provider report the ALA taken on their license/ accreditation?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Provider's accreditation/ medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | Yes | MACs shall check whether the provider billed for dates of service during the period of license suspension/revocation/surrender during disciplinary proceedings. If the provider billed for dates of service during this period, the MACs shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov.<br><br>If the provider did not bill during the period of license suspension, the application shall be processed unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.2 – 2.8. | MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/revocation/ surrender. e.g. Felonies. |
| Provider's accreditation/ medical license was previously suspended/revoked in any state/voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing | No | MACs shall check whether the provider billed for dates of service during the period of license suspension/revocation. If the provider billed for dates of service during this period, the MACS shall send the application and ALA information to ProviderEnrollmentRevocations@cms.hhs.gov.<br><br>If the provider did not bill for dates of service during this period, the provider shall be revoked under 42 CFR § 424.535 (a)(4).<br><br>If a license suspension/revocation /surrender in lieu of disciplinary proceeding occurred more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.gov for review and decision.<br><br>MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.2 – 2.8. | 42 CFR § 424.535 (a)(4) shall ONLY be included as a revocation reason, if the provider has never reported this adverse action.<br><br>MACs shall read board orders thoroughly to determine if:<br><br>- there are other adverse actions associated with the license suspension/revocation/ surrender. e.g. Felonies<br><br>No Reporting Requirement:<br><br>A suspension is "stayed" in its entirety.<br><br>Advertising/Administrative penal- ties<br><br>Fines, Violations, Stipulations, Reprimands |

## 2.2 FELONIES — REVALIDATION/ CHANGE OF INFORMATION APPLICATIONS

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

## 2.2 MISDEMEANORS – REVALIDATION/ CHANGE OF INFORMATION APPLICATION

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

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

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

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

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

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

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

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

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

## 2.7 MEDICARE REVOCATION – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS

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

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

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

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

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

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

### A. Practice and Administrative Location Verification

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

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

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

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

Also:

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

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

**B. Do Not Forward (DNF)**

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

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

**C. Remittance Notices/Special Payments**

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

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

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

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- An updated section 4 that identifies the provider's desired "special payments" address.

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

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

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

- One of the provider's practice locations

- A P.O. Box

- A Lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement, at least with respect to any special payments that might be made, may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a Part A chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.

- Correspondence address

## 15.5.4.1 – Section 4 of the Form CMS-855A

**(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)**

## A. General Information

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

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

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

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

## B. Verification of HHA Sites

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

## C. Out-of-State Practice Locations

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

- The location is not part of a separate organization (e.g., a separate corporation, partnership),

- The location does not have a separate tax identification number (TIN) and

legal business name (LBN),

- The State in which the new location is being added does not require the location to be surveyed,

- The applicable RO does not require the new location or its owner to sign a separate provider agreement, and

- The location is not a federally qualified health center (FQHCs are required to separately enroll each site)

Consider the following examples:

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

2. The contractor's jurisdiction consists of States X, Y and Z. JSNF, Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate legal entity - JSNF, LP. The fourth location must be enrolled via a separate, initial Form CMS-855A.

3. The contractor's jurisdiction consists of States X, Y and Z. Jones Hospice (JH), Inc., is enrolled in State X with 1 location. It wants to add a second location in State Z under JH, Inc. However, it has been determined that a separate survey and certification of the new location are required. A separate, initial Form CMS-855A for the new location is required.

## 15.5.4.2 – Section 4 of the Form CMS-855B

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

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

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

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

**B. Reassignment of Benefits**

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

**C. Ambulance Companies**

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

- Each site at which its vehicles are garaged in section 4A. (The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)

- Each site from which its personnel are dispatched in section 4A. (The site is considered a practice location for enrollment purposes, including with respect to payment of the application fee.)

- Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E. (The supplier can only have one base of operations.)

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

**D. Out-of-State Practice Locations**

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

- The location is not part of a separate organization (e.g., a separate corporation, partnership),

- The location does not have a separate tax identification number (TIN) and legal business name (LBN),

- The State in which the new location is being added does not require the location to be surveyed,

- The applicable RO does not require the new location or its owner to sign a

separate supplier agreement, and

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

Consider the following examples:

1. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y. The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no State or RO involvement with group practices, all 5 conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.

2. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.

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

4. The contractor's jurisdiction consists of States X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Z under JASC, Inc. However, it has been determined that a separate survey and certification of the new site are required. A separate, initial Form CMS-855B is therefore necessary.

## 15.5.4.3 – Section 4 of the Form CMS-855I

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

### A. Solely-Owned Organizations

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

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

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

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

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

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

**B. Individual Affiliations**

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

**C. Practice Location Information**

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

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

**D. Sole Proprietor Use of EIN**

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

**E. NPI Information for Groups**

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

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

**F. Out-of-State Practice Locations**

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

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

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

## 15.5.4.4 – Section 4 of the Form CMS-20134

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

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

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

**A. Administrative Locations**

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

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

All administrative locations related to the MDPP supplier must be disclosed, however, given that MDPP suppliers may be non-traditional health care providers engaged in non-health care related activities, not all organizations run by the entity may constitute an administrative location. For example, if an advocacy organization operated 2 sites, however only one of these sites offered MDPP services, only the site offering MDPP would be considered an administrative location. Should a coach be based or dispatched from their non-administrative location site to offer MDPP services in community settings, that location would become an administrative location. Detail on the frequency with which MDPP suppliers must report this change is outlined in 15.4.6.4.C**.**
Given that MDPP suppliers are designated as high categorical risk, their administrative locations are subject to site visits. Additional information for the site visit is outlined in 15.6.1.1.3.

**B. Community Settings**

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

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

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

**C. Out-of State Administrative Locations**

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

- The location is not part of a separate organization (e.g., a separate corporation, partnership),

- The location does not have a separate tax identification number (TIN) and legal business name (LBN),

- The location has the same CDC organizational code

Consider the following examples:

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

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

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

3. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 administrative locations. It wants to add a fourth location in State Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-20134.
4. The contractor's jurisdiction consists of States X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Q. Since State Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.

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

## 15.5.5 – Owning and Managing Organizations

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

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

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

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

The following illustrates the difference between direct and indirect ownership:

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

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

**2. Mortgage or security interest**

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

control exists when:

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

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

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

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

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

**5. Managing control of the provider or supplier**

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

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

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

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

The following principles also apply with respect to section 5:

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

- The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other. (This applies to the Form CMS-855A, CMS-855B, CMS-855S, and CMS-20134.)

- If the provider is a skilled nursing facility (SNF), it must submit a diagram/flowchart identifying the organizational structures of all of its owners, including those that were not required to be listed in section 5 or 6. This must be submitted in addition to the diagram/flowchart in the previous bullet.

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

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

- Disclose a percentage of managerial control

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

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

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

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

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

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

f. IRS CP-575 - Owning/managing organizations need not furnish an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a potential discrepancy between the organization's reported legal business name and tax identification number.

g. Documentation – Proof of ownership, managerial control, security interest, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.

h. Partnerships – Only partnership interests in the enrolling provider need be disclosed in section 5. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 5.

i. Disregarded Entities – In general, a "disregarded entity" is a term the IRS uses for an LLC that – for federal tax purposes only – is effectively indistinguishable from its single owner/member. The LLC's income and expenses are shown on the owner's personal tax return. The LLC itself does not pay taxes.

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

## 15.5.6 – Owning and Managing Individuals

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

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

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

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

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

2. A 5 percent or greater mortgage or security interest in the provider.

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

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

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

5. Managing control of the provider. (For purposes of enrollment, such a person is considered to be a "managing employee." A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.)

6. Officers and directors/board members, if – and only if - the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors. If a non-profit corporation has "trustees" instead of officers or directors, these trustees must be listed in section 6 of the Form CMS-855 or the Form CMS-20134.) Only officers and directors of the enrolling provider must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in section 6. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner's officers and directors/board members would have to be disclosed as the provider's officers and directors/board members in section 6.

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

In addition:

- The provider need not disclose a percentage of: (1) control as an officer or director, (2) W-2 or contracted managerial control, or (3) operational control. Also, the provider need not submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.

- Government entities need only list their managing employees in section 6 of the Form CMS-855, as they do not have owners, partners, corporate officers, or corporate directors.

- The applicant must list at least one managing employee in section 6 if it is completing the Form CMS-855A, the Form CMS-855B or the Form CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if he/she does not have one.

- All managing employees at any of the practice locations listed in section 4C of the Form CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the chief executive officer of a hospital listed in section 4C), or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, need not be reported.

- The contractor need not request a copy of the individual's W-2 to confirm that he/she is a W-2 employee (as opposed to a contracted employee), although it reserves the right to do so.

- Proof of ownership, managerial control, security interests, etc., need not be submitted unless the contractor requests it.

- Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. Of course, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 6.

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

## 15.5.6.1 – Tax Identification Numbers (TINs) of Owning and Managing Organizations and Individuals

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

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

a. The contractor shall ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN). (Only one inquiry is needed.)

   (1) If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.

   (2) If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN, and (ii) the provider must furnish the TIN/ITIN on the Form CMS-855 with a newly-signed certification statement within 90 days of the contractor's request.

   (3) If the provider states that the person or entity is unable to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN, and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.

b. If the provider timely submits the explanation in (a)(3) above, the contractor shall forward the explanation to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). PEOG will notify the contractor as to how the application should be handled.

c. If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN in (a)(2), the contractor shall – unless another CMS instruction directs otherwise - reject the application in accordance with the procedures identified in this chapter.

In addition:

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

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

## 15.5.7 – Chain Organizations

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

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

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

- Chain provider - A group of two or more providers under common ownership or control.

- Common control - Exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.

- Common ownership – Exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

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

In addition, the contractor shall ensure that:

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

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

For more information on chain organizations, refer to:

- Pub. 100-04, chapter 1, sections 20.3 through 20.3.6

- 42 CFR §421.404

- CMS change request 5720

## 15.5.8 – Billing Agencies

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

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

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

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

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

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

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

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

### A. Background Information

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

### B. Coach Eligibility and Screening

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

- Currently have Medicare billing privileges revoked and be currently subject to a reenrollment bar.
- Currently have its Medicaid billing privileges terminated for-cause or be excluded by a State Medicaid agency.
- Currently be excluded from any other Federal health care program, as defined in 42 CFR 1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
- Currently be debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.
- Have, in the previous 10 years, one of the following State or Federal felony convictions:
    - Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.
    - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the

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

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

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

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

**C.. Coach Eligibility Start and End Dates**

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

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

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

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

**D. Consequences for Coach Ineligibility**

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

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

**E. Special Revocation for Knowingly Using an Ineligible Coach**

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

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

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

Further details are outlined in 15.27.3.C.

## 15.5.10 – Reserved for Future Use
**(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)**

## 15.5.11 – Reserved for Future Use
**(Rev. 416, Issued: 04-13-12, Effective: 02-27-12, Implementation: 02-27-12)**

## 15.5.12 – Special Requirements for Home Health Agencies (HHAs)
**(Rev. 423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)**

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

A. Capitalization

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

B. Nursing Registries

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

## 15.5.13 – Contact Persons
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

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

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

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

- The contractor may use multiple contact persons throughout the enrollment process; it need not use the same individual for the entire duration unless, again, the provider indicates otherwise.

- All contact persons shall be stored in PECOS and shall not be removed unless the provider requests the removal via letter, email, or fax. Currently there is no option on the CMS-855 or CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 or CMS-20134 form.

- If the contractor discovers that a particular contact person qualifies as an owning or managing individual, the contractor shall develop to the provider to determine if the person should be listed in section 6 of the application.

- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

## 15.5.14 – Certification Statement Signature Requirements

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

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

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

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

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

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

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

## 15.5.14.2 - Form CMS-855R Signatories

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

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

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

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

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

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

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

## 15.5.14.3.1 - Authorized Officials

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

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

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

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

1. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

2. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data or to sign revalidation applications.

3. Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an

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

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

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

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

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

## 15.5.14.3.2 – Delegated Officials

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

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

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

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

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

The contractor shall note the following about delegated officials:

1. Authority - A delegated official has no authority to sign an initial application. However, the delegated official may (i) sign a revalidation application and (ii) sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial application.

2. Section 6 – Section 6 of the Form CMS-855 and CMS-20134 must be completed for all delegated officials.

3. Managing Employees - For purposes of section 16 <u>only</u>, the term "managing employee" means any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2

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

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

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

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

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

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

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

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

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

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

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

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

### A. Paper Submissions

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

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.

- The certification statement may be returned via scanned email or fax.

- Signature dates cannot be prior to 120 days of the receipt date of the application.

- For paper applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that must be sent in within 30 days; obtaining the signatures of the other authorized and delegated officials is not required.

- For paper changes of information applications (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the

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

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

## B. Internet-based PECOS Submissions

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

- The contractor shall begin processing the application upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review.

- Signature dates cannot be prior to 120 days of the receipt date of the application.

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

- For Internet-based PECOS applications that require development, it is only necessary that the dated signature of at least one of the provider's authorized or delegated officials be on the certification statement that

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

- For Internet-based PECOS changes of information applications (as the term "changes of information" is defined in section 15.6.2 of this chapter), if the certification statement is signed by an individual who is not on file with the contractor as being an authorized or delegated official of the provider, the contractor may accept the certification statement but shall develop for information on the person in question in accordance with sections 15.5.14.3.1 and 15.5.14.3.2 of this chapter.

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

## 15.5.14.5 – Certification Statement Development

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

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

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

## 15.5.15 – Reserved for Future Use

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

## 15.5.15.1 – Form CMS-855I Signatories

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

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

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

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

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

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

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

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

In addition:

1. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

2. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes

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

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

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

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

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

7. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a

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

## 15.5.16 – Supporting Documents

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

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

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

## 15.5.17 – Supporting Documents for MDPP Suppliers - Recognition Status

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

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

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

### A. Supporting Documents for MDPP Preliminary recognition

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

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

**B. Supporting Documents for Full CDC Recognition**

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

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

## 15.5.20 – Processing Form CMS-855R Applications

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

**A. General Information**

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

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

15.7.6 for additional instructions regarding the joint processing of Form CMS-855As, Form CMS-855Rs, Form CMS-855Bs, and Form CMS-855Is.)

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

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

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

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

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

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

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

Under Method I:

- The CAH bills for facility services

- The physicians/practitioners bill separately for their professional services

Under Method II

- The CAH bills for facility services

- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service

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

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

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

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

**C. Ambulatory Surgical Centers (ASCs) and Reassignment**

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

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

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

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

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

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

(1) The practice's enrollments have been deactivated;

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

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

**E. Miscellaneous Reassignment Policies**

1. A Form CMS-855R is required to terminate a reassignment. The termination cannot be done via the Form CMS-855I (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment).

2. The authorized or delegated official who signs section 6 of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(s) CMS-855A or CMS 855B, Form CMS-855I, and Form CMS-855R - the person must be listed on the CMS-855A or CMS-855B as an authorized or delegated official.

3. If the Form CMS-855R is accompanied by an initial Form CMS-855I or submitted as a "stand-alone" form (that is, a Form CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in section 15.17 of this chapter.

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

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

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

- Report employment arrangements of physician assistants (PAs); employment arrangements for PAs must be reported on the Form CMS-855I.

- Revalidate reassignments; the individual practitioner should only use the Form CMS-855I and list his or her active reassignment information in section 4B thereof.

- Go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending to view the CMS-855R Processing Guide, which constitutes a general Form CMS-855R processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855R, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855R applications.

**F. Reassignment Termination Effective Date**

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

## 15.5.20.1 – Inter-Jurisdictional Reassignments

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

**A. General Policy**

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

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

interprets test results in his home for an independent diagnostic testing facility).

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

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

- Shall identify the reassignor's practice location as its practice location on its Form CMS-855B

- In Section 4A of its Form CMS-855B shall select the practice location type as "Other health care facility" and specify "Telemedicine location."

- Need not be licensed/authorized to perform services in the reassignor's state.

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

**B. Applicability**

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

## 15.6 - Timeliness and Accuracy Standards

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

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

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

- Receipt of the application or opt-out affidavit in the contractor's mailroom and forwarding it to the appropriate office for review.

- Prescreening the application or opt-out affidavit.

- Creating a logging and tracking (L & T) record and an enrollment or opt-out affidavit record in the Provider Enrollment, Chain and Ownership System (PECOS).

- Ensuring that the information on the application or opt-out affidavit is verified.

- Requesting and receiving clarifying information.

- Site visit (if necessary).

- Formal notification to the SA and/or RO of the contractor's approval, denial or recommendation for approval of the application.

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

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

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

1. Form CMS-855 or Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the new owner.

2. "Complete" Form CMS-855 or Form CMS-20134 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), (c) as a Form CMS-855 or Form CMS-20134reactivation, or (d) as a revalidation.

3. Reactivation certification packages (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter).

4. Opt-out affidavits submitted for an eligible practitioner's first opt-out period.

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

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

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

### 15.6.1.1.1 – Form CMS-855 and Form CMS-20134 Applications That Require a Site Visit
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

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

### 15.6.1.1.2 – Form CMS-855 and Form CMS-20134 Applications That Do Not Require a Site Visit and Opt-Out Affidavits
**(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

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

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

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

## 15.6.1.3 - Web-Based Applications - Timeliness
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

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

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.

- Verification of the application in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

- Supplier site visit (if required).

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

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

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.

- Verification of the application in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

- Supplier site visit.

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

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

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

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.

- Verification of the application in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

## 15.6.1.4 - Web-Based Applications - Accuracy

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

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

## 15.6.2 – Standards for Changes of Information

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

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

1. Form CMS-855 and Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the old owner

2. Form CMS-588 changes submitted without a need for an accompanying complete Form CMS-855 or Form CMS-20134 application

3. Form CMS-855R applications submitted independently (i.e., without being part of a Form CMS-855I or Form CMS-855B package)

4. Form CMS-855 and Form CMS-20134 voluntary terminations

5. Opt-out early termination requests (of initial opt-out affidavits), changes of information and cancellation requests

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

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

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

- Receipt of the change or opt-out termination request, cancellation request, or other change of opt-out information in the contractor's mailroom and forwarding it to the appropriate office for review.

- Prescreening the change request in accordance with existing instructions.

- Creating an L & T record and, if applicable, tying it to an enrollment or opt-out affidavit record in PECOS.

- Verification of the change request in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

- Supplier site visit (if necessary).

- Formal notification of the contractor's decision or recommendation (and providing the appropriate appeal rights, as necessary).

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

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

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

## 15.6.2.3 - Web-Based Applications - Timeliness

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

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

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review. (This obviously does not apply to applications submitted with an electronic signature.)

- Ensuring that the changed information has been verified

- Requesting and receiving clarifying information

- Supplier site visit (if necessary)

- Formal notification to the SA and/or RO of the contractor's approval, denial or recommendation for approval of the application.

## 15.6.2.4 - Web-Based Applications – Accuracy

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

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

## 15.6.3 - General Timeliness Principles

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

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

### A. Clock Stoppages

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

- Referring an application to the Office of Inspector General (OIG) or the Zone Program Integrity Contractor.

- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).

- Waiting for the regional office (RO) to make a provider-based or CHOW determination.

- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number.

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

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

**B. Calendar Days**

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

**C. Date-Stamping**

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

- Any Form CMS-855 or Form CMS-20134 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)

- Letters from providers. (The first page of the letter must be date-stamped.)

- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)

- Data that the provider furnishes (via mail or fax) per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because many contractors interleaf the new/changed pages within the original application. Thus, it is necessary to determine the sequence in which the application and the additional pages were received.)

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

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

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

**D. When the Processing Cycle Ends**

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

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

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

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

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

**E. PECOS**

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

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

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

- For applications that require an application fee, no later than 20 calendar days after:

  - The date on which the provider paid the fee – as confirmed by either the Fee Submitter List or the provider's submission of a receipt of payment from Pay.gov, or

  - The date on which PEOG approved the provider's hardship exception request (or, for suppliers of durable medical requirement, prosthetics, orthotics and supplies, the date on which the NSC approved the hardship exception request).

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

The L & T and enrollment record requirements in the previous paragraph apply to all applications identified in sections 15.6.1 through 15.6.2.4 of this chapter (e.g., reassignments, CHOW applications submitted by old and new owners).
In situations where the contractor cannot create an L & T record within 20 days due to missing information (e.g., no NPI was furnished), the contractor shall document the provider file accordingly.

## 15.7.1.3 – Verification of Data/Processing Alternatives

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

### A. Verification - General

1. Means of Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify and validate – via the most cost-effective methods available - all information furnished by the provider on or with its application. The general purpose of the verification process is to ensure that all of the data furnished on the Form CMS-855 or Form CMS-20134 is accurate.
Examples of verification techniques include, but are not limited to:

- Site visits

- Third-party data validation sources

- State professional licensure and certification Web sites (e.g., medical board

sites)

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

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

2. Procedures

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

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

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

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

OR

(b) Concluding that the furnished data is accurate.

3. Concurrent Reviews

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

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

4. Contacting Other Contractor

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

**B. Processing Alternatives**

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

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

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

**A. General Processing Alternatives**

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

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

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

b. All ownership and managing control information in section 5A and 6A of the Form CMS-855B

c. The applicants legal business names (LBN) or legal names
Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop. (This also applies to Employer's Name for PA's in section 2E of the Form CMS-855I)

d. Tax identification numbers (TIN)
e. NPI-legacy number combinations in Section 4 of the Form CMS-855
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

f. Supplier/practitioner type (section 2A of the Form CMS-855B and section 2D of the Form CMS-855I)

2. Licenses

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

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

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception is moot in cases where:

(1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

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

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

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

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

**B. Sectional Processing Alternatives**

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

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

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

2. Section 2

a. Form CMS-855B

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

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2A2, no further development is needed.

b. Form CMS-855I

- If blank, "Type of Other Name" and "Gender" can be captured orally.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2A, no further development is needed.

- In section 2D1, if the supplier uses a checkmark, an "X," or other symbol to identify his/her primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information is disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. <u>Section 4</u>

a. Form CMS-855B

- In section 4A, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, or fax.

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855.

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the

supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-855.

- In section 4F, if the vehicle certificates are furnished but the applicable Form CMS-855 sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the supplier has.

b. Form CMS-855I

- If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.

- In section 4C, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor; the contractor can confirm the information via telephone, email or fax.
- In section 4E, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4E must be completed via the Form CMS-855.

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

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

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).

- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).

- Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall

document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

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

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

7. Attachment 1 (Form CMS-855B)

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

8. Attachment 2 (Form CMS-855B)

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

**C. Supporting Documents**

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

## 15.7.1.3.2 – Processing Alternatives – Form CMS-855A

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

**A. General Processing Alternatives**

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

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

a. Any final adverse action data requested in sections 3, 5B and 6B of the Form CMS-855A

b. All ownership and managing control information in section 5A and 6A of the Form CMS-855A

c. All legal business names (LBNs)(e.g., provider, chain home office)
Note: If an application is submitted with a valid NPI and OSCAR combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855A and the contractor is able to confirm the correct LBN based on the NPI and OSCAR combination provided, the contractor is not required to develop.

d. All tax identification numbers (TINs)(e.g., provider, owning organization)

e. NPI-legacy number combinations in section 4 of the Form CMS-855A
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

f. Provider type

g. The following data in sections 2F, 2G and 2H:

- "Doing business as" name
- Effective dates of sale/transfer/consolidation
- Checkbox in section 2F indicating whether seller will accept assets/liabilities
- Names of units with separate legacy numbers/NPIs;
- All NPIs and legacy numbers
  Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the OSCAR or NPI before developing to the provider.

2. Licenses - In situations where the provider is required to submit a copy of a particular professional or business license, certification, or registration but fails to do so, the contractor need not obtain such documentation from the provider if the

contractor can verify the information independently. This may be done by: (1) reviewing and printing confirmation pages from the applicable state web site, (2) requesting and receiving from the appropriate state body written confirmation of the provider's status therewith, and (3) using any other third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, or registration but fails to complete the appropriate section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

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

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, or certifications. It does not apply to items such as adverse action documentation, bills of sale, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed.

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

**B. Sectional Processing Alternatives**

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

1. Section 1

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

2. Section 2

- Other than the TIN and the LBN, all information in section 2B1 can be captured by telephone, email, fax, or a Web site.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes in section 2B2 are not checked, no further development is needed.

- With respect to sections 2F, 2G, and 2H, if the old/new owner's current contractor is not listed, the contractor can research this data on its own or obtain it from the provider by any means.

3. Section 4

- In section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via email or fax.

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the provider by telephone, email, or fax to confirm the provider's intentions. If the provider replies that the "special payments" address is the same as the practice location, no further development is needed. If, however, the provider wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855A.

- In section 4D, if the "Check here" box is not checked and no address is provided, the contractor can contact the provider by telephone, email or fax to confirm the provider's intentions. If the provider replies that the base of operations address is the same as the practice location, no further development is needed. If the provider indicates that the base of operations is at a different location, the address in 4D must be completed via the Form CMS-855A.

- In section 4E, if the vehicle certificates are furnished but the applicable CMS-855A sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the provider has.

4. Section 7

- If all of section 7 is blank (including the check box just above section 7A), no additional development is necessary.

- If the provider indicates that it is part of a chain but the checkboxes in section 7A are blank, the contractor can verify the type of transaction involved via email or fax.

- In section 7B, if the person is also listed with complete information in section 6A (e.g., the individual's Social Security Number (SSN) is listed in section 6A1), only the individual's first and last name need be listed in section 7B.

- In section 7C, if the entity is also listed with complete information in section 5A, the company's legal business name is the only data that must be listed in section 7C. (If blank, the cost report date, the home office's contractor, and the chain number can be developed by phone, email, or fax.)

- If blank, data in section 7D can be collected by telephone, email or fax.

- If blank, data in section 7E can be collected by email or fax.

5. Section 8

   - If the telephone number is blank, the number can be verified with the provider by telephone, email or fax.

   - If all of section 8 is blank (including the check box), no additional development is necessary.

6. Section 12

   - If it is obvious that the entity is not enrolling as a home health agency (HHA), the checkbox above section 12A can be left blank.

   - If the entity is an HHA:

     - If section 12A1 or 12A3B is blank, the data can be verified by telephone, email, or fax.

     - If the telephone number in section 12B is blank, the number can be verified with the provider by telephone, email or fax.

7. Section 13

   - If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.
   - If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor may either (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.

   - Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

8. Sections 15 and 16

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

### C. Supporting Documents

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

## 15.7.1.3.3 – Processing Alternatives – Form CMS-855O

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

### A. General Processing Alternatives

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

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

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

2. Licenses

In situations where the supplier is required to submit a copy of a particular

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

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

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees such as adverse action documentation. Furthermore, the exception is moot in cases where a particular license/certification is not required by the state.

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

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

**B. Sectional Processing Alternatives**

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

1. Section 1

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

2. Section 2

- If blank, "Type of Other Name" and "Gender" can be captured orally.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2C, no further development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information if disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. Section 4

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

4. Section 6

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

**C. Supporting Documents**

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

## 15.7.1.3.4 – Processing Alternatives – Form CMS-855R

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

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

Regarding section 2:

- If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 2 of the Form CMS-855R, and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
- MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the group/organization/individual that is receiving the reassigned benefits before developing to the provider for existing individual practitioners only. If information is missing from the 855R that cannot be verified in PECOS, the Shared Systems or provider files, then a development would have to be issued (i.e.: group information is missing from the 855R and not included in the 855I Section 4, this cannot be verified elsewhere).

Regarding section 3:

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

Regarding section 5:

- If this section is completely blank, the contractor need not develop for this information and can simply contact the party that submitted the form (e.g., the enrolling physician).

- If a contact person is listed, any other missing data (e.g., address, e-mail) can be captured via telephone.

## 15.7.1.3.5 - Processing Alternatives – Form CMS-20134

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

### A. General Processing

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

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

even if the data is identified elsewhere on the form or in the supporting documentation:

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

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

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

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

d. Tax identification numbers (TIN)

e. NPI-legacy number combinations in Section 4 of the Form CMS-20134
   Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

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

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

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

2. <u>City, State, and ZIP Code</u> - If an address (e.g., correspondence address, practice location) lacks a city, state or zip + four, the contractor can verify the missing data

in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

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

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

**B. Sectional Processing Alternatives**

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

1. Section 1

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

2. Section 2

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

3. Section 4

- In section 4A, the type of location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, or fax.

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the administrative location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-20134.

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-20134.

4. Section 7

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

5. Section 8

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

6. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.

- Currently there is no option on the CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the Form CMS-20134.

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

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

**C. Supporting Documents**

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

information submitted along with opt-out applications for enrollment application processing or vice-versa.

## 15.7.4 - Tie-In Notices

**(Rev. 404, Issued: 01-20-12, Effective: 04-22-12, Implementation: 04-22-12)**

Although it may vary by regional office (RO), tie-in and tie-out notices are generally issued in the following circumstances:

- Initial enrollment
- Change of Ownership (CHOW) under 42 CFR §489.18
- Acquisition/Merger
- Consolidation
- Addition or deletion of home health agency (HHA) branch, hospital unit, or outpatient physical therapy extension site
- Voluntary and involuntary termination of billing numbers

As each RO may have different practices for issuing tie-in and tie-out notices, the contractor should contact its RO to find out the specific circumstances in which such notices are issued. This also applies to instances where the RO delegates the task of issuing tie-in or tie-out notices to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the latter has indeed delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

In addition:

- **Approval Letters** – Depending on the RO, an approval letter may be issued in lieu of a tie-in notice.

- **Review for Consistency** - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the CMS-855. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the RO to determine why the data is different.

- **Receipt of Tie-In When CMS-855 Not Completed** - If the contractor receives a tie-in notice from the RO but the provider never submitted the necessary Form CMS-855 application, the contractor shall immediately alert the RO of the situation. The contractor shall also contact the provider and have it complete and submit the required application. (This applies to initial applications, CHOWs, practice location additions, etc.)

- **Creation of New Logging & Tracking (L & T) Record Unnecessary** - The contractor is not required to create a new L & T record in the Provider

Enrollment, Chain and Ownership System when the tie-in notice comes in, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

Note that 42 CFR §489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and (2) such requirements include the contractor's review and verification of an application to enroll in the Medicare program. (See sections 15.17.4 and 15.26.3 of this chapter for more information.)

## 15.7.5 – Special Program Integrity Procedures

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

This section contains additional verification procedures that the contractor shall utilize when processing the following transactions:

- Changes in the provider's practice location
- Change in the special payment address
- On the Form CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number

- Revalidations and Form CMS-855 or Form CMS-20134 Reactivations

The instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter and in other CMS directives. Also, unless otherwise stated, section 15.7.5 applies to the Form CMS-855A, Form CMS-855B, Form CMS-855I, and Form CMS-20134.

**A. Change in Practice Location Address**

In cases where a provider submits a Form CMS-855 or Form CMS-20134 request to change its practice location address, the contractor shall undertake the following activities:

1. Contact the location currently associated with the provider in the Provider Enrollment, Chain and Ownership System (PECOS) or the Multi-Carrier System (MCS) to verify that the provider is no longer there and did in fact move.

**B. Change in Special Payments Address**

If the provider submits a change to its special payments address, the contractor shall contact the individual physician/practitioner (for Form CMS-855I changes), an authorized or delegated official (for Form CMS-855A, Form CMS-855B, and Form CMS-20134 changes), or the contact person listed in section 13 (for Form CMS-

855A, Form CMS-855B, Form CMS-20134, and Form CMS-855I changes) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

**C. Change of EFT Information**

If the provider submits a Form CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A, Form CMS-855B, and Form CMS-20134 enrollees), or the section 13 contact person on record (for Form CMS-855A, Form CMS-855B, Form CMS-20134, and Form CMS-855I enrollees) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

**D. Revalidations and Form CMS-855 or Form CMS-20134 Reactivations**

When processing a revalidation or Form CMS-855 or Form CMS-20134 reactivation application, the contractor shall – unless another CMS directive instructs otherwise - the contractor shall abide by the instructions in subsections A and B above, respectively, if the (a) practice location address or (b) special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS.

**E. Reassignment of All Benefits**

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, professional association, or limited liability company, the contractor shall call the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner.

**F. Potential Identity Theft or Other Fraudulent Activity**

In conducting the verification activities described in this section 15.7.5, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is <u>not</u> establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) immediately; the BFL will instruct the contractor as to what, if any, action shall be taken.

## 15.7.5.1 – Special Procedures for Physicians and Non-Physician Practitioners

**(Rev. 521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)**

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

### A. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

1. Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);

2. Otherwise lost their medical license or have had their licenses expire.

For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps to revoke the individual's billing privileges.

The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

### B. Relocation to a New State

#### 1. Licensure Reviews

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall review State licensing board information for the "prior" State to determine:

1. Whether the practitioner had his or her medical license revoked, suspended, or inactivated (due to retirement, death, or voluntary surrender of license), or otherwise lost his or her license, and

2. If the practitioner has indeed lost his or her medical license, whether he or she reported this information to Medicare via the CMS-855I within the timeframe specified in 42 CFR 424.520.

If the practitioner is currently enrolled and did not report the adverse action to Medicare in a timely manner, the contractor shall revoke the practitioner's Medicare billing privileges and establish a 1-year enrollment bar. If the practitioner is submitting an initial enrollment application (e.g., is moving to a new State and contractor jurisdiction) and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application and establish a 3-year enrollment bar.

**2. Voluntary Withdrawal Reminder**

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall determine whether the practitioner still has an active PECOS enrollment record in the "other" State(s). If PECOS indeed indicates that the individual has an active practice location in the other State(s), the contractor shall remind the practitioner that if he/she no longer intends to practice in that State, he/she must submit a CMS-855 voluntary termination application to the contractor for that jurisdiction. The reminder should be given in the approval letter that the receiving contractor sends to the practitioner or, if more appropriate, in an e-mail or other form of written correspondence.

**C. Break in Medical Practice**

If the contractor receives a CMS-855I from a practitioner who was once enrolled in Medicare but who has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the State where the practitioner last worked whether the practitioner was convicted of a felony or had his or her license suspended or revoked. If such an adverse action was imposed, the contractor shall take action in accordance with the instructions in this chapter.

**D. State Relationships**

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

## 15.7.5.2 – Special Procedures for MDPP Suppliers

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

To help ensure that only qualified MDPP suppliers are enrolled in Medicare and only eligible coaches are interacting with MDPP beneficiaries, the contractor shall undertake the activities described below.

**A. Recognition Status**

CMS will notify any contractor when an MDPP supplier within their jurisdiction has moved from preliminary or full recognition down to pending, and therefore no longer maintains eligibility for an MDPP supplier.

For those suppliers that no longer have a valid recognition level to maintain their MDPP supplier enrollment, the contractor shall take the necessary steps to revoke the supplier's billing privileges.

## 15.7.6 - Special Processing Guidelines for Form CMS-855A, Form CMS-855B, and Form CMS-855I Applications

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

The contractor shall abide by the following:

- If an individual is joining a group that was enrolled prior to the Form CMS-855A or Form CMS-855B (i.e., the group or CAH II never completed a Form CMS-855), the contractor shall obtain a Form CMS-855A from the CAH II or Form CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group solely on the grounds that a Form CMS-855A or Form CMS-855B has not been completed. Once the group or CAH II's application is received, the contractor shall add the new reassignment; if the Form CMS-855R was not submitted, the contractor shall secure it from the provider or supplier.

- If a provider or supplier is changing its TIN, the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the provider or supplier must complete a full Form CMS-855 or Form CMS-20134 application and a new enrollment record must be created in PECOS. (This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a change of ownership is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)

- If the provider or supplier is adding or changing a practice location and the new location is in another state within the contractor's jurisdiction, the contractor shall ensure that the provider or supplier meets all the requirements necessary to practice in that State (e.g., licensure). A complete Form CMS-855 or Form CMS-20134 for the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new state.

- All members of a group practice must be entered into PECOS.

## 15.7.7 – Special Processing Guidelines for Form CMS-855A Applications

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

Unless otherwise stated, all references to the "RO" in sections 15.7.7.1 through 15.7.7.7 of this chapter refer to the RO's survey & certification staff.

## 15.7.7.1 - Changes of Ownership (CHOWs)

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

Changes of ownership (CHOWs) are officially defined in and governed by 42 CFR §489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The RO – not the contractor – makes the determination as to whether a CHOW has occurred (unless this function has been delegated).

Unless specified otherwise, the term "CHOW" - as used in sections 15.7.7.1 through 15.7.7.1.6 of this chapter - includes CHOWs, acquisitions/mergers and consolidations.
Though section 2 of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers and consolidations for ease of disclosing and reporting, they fall with the general CHOW category under 42 CFR §489.18 (e.g., an acquisition/merger is a type of CHOW under §489.18).

### 15.7.7.1.1 - Definitions

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

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the Form CMS-855A application:

- **"Standard" CHOW** – This occurs when a provider's CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

This is the most frequently encountered change of ownership scenario. As explained in section 15.7.7.1, even though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the "CHOW" category – as opposed to the "Acquisition/Merger" category – on the Form CMS-855A.

- **Acquisition/Merger** - In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to

merge. Entity B's CCN number and provider agreement will be eliminated (leaving only Entity A's CCN number and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in section 1A of the Form CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire Form CMS-855A. This is because the new owner is already enrolled in Medicare. As such, the provider being acquired should be reported as a practice location in section 4 of the new owner's Form CMS-855A.

- **Consolidations** - This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated. Entity C will have its own CCN number and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a consolidation, when A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

Under 42 CFR §489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Publication 100-07, chapter 3, section 3210.1D (4) for more information.)

Note that a provider may undergo a financial or administrative change that it considers to be a CHOW, but does not meet the regulatory definition identified in §489.18.

## 15.7.7.1.2 - Examining Whether a CHOW May Have Occurred

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

As stressed in section 15.7.7.1, the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW may have occurred, and/or (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Such research may include reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. (A CHOW determination by the RO is usually not required prior to the contractor making its recommendation.)

While a CHOW is usually accompanied by a tax identification number (TIN) change, this is not always the case. There may be isolated instances where the TIN remains the same. Conversely, there may be cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, the contractor should review the sales/lease agreement closely, as this will help indicate whether a CHOW may or may not have occurred.

In addition:

(1) If the provider claims that the transaction in question is a stock transfer and not a CHOW, the contractor reserves the right to request any information from the provider to verify this (e.g., copy of the stock transfer agreement).

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the RO for guidance. Such referrals to the RO should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment may have taken place and should not be made as a matter of course. A RO CHOW determination is usually not required prior to the contractor making its recommendation.

(2) There may be instances where the contractor enters a particular transaction into the Provider Enrollment, Chain and Ownership System (PECOS) as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in the provider's file that the transaction was not a CHOW.

## 15.7.7.1.3 - Processing CHOW Applications

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

Unless stated otherwise in this chapter, the contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owners are completed in accordance with the instructions on the Form CMS-855A.

### A. Old Owners

The old owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the old owner's Form CMS-855A is available at the time of review, the contractor

shall examine the information thereon against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the old owner's Form CMS-855A has not been received, the contractor shall contact the old owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the old owner's application. It may also make its recommendation to the State agency without having received the old owner's Form CMS-855A. The contractor, of course, shall not make a recommendation for approval unless the new owner has checked on the form that it will assume the provider agreement and the terms of the sales agreement indicate as such.

If a certification statement is not on file for the old owner, the contractor shall request that section 6 be completed for the individual who is signing the certification statement.

Note that an old owner's Form CMS-855A CHOW application is essentially the equivalent of a Form CMS-855 voluntary termination submission, as the seller is voluntarily leaving the Medicare program. As such, the contractor shall not require the seller to submit a separate Form CMS-855 voluntary termination along with its Form CMS-855A CHOW application.

**B. New Owners**

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's Form CMS-855A, the contractor shall contact the new owner. If the new owner fails to: (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the contractor contacted it, the contractor shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the contractor ascertains that the provider accepts assignment.

**C. Order of Processing**

To the maximum extent practicable, Form CMS-855A applications from the old and new owners in a CHOW should be processed as they come in. The contractor should not wait for applications from both the old and new owner to arrive before processing them. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the old and new applications to the State simultaneously, rather than as soon as they are processed. For instance, suppose the old owner submits an application on March 1. The contractor should begin processing the application immediately, without waiting for the arrival of the new owner's application. Yet it should avoid sending the old owner's application to the State until the new owner's application is processed. (For acquisition/mergers and consolidations, the contractor may send the applications to the RO separately, since one number is going away.)

## D. Sales and Lease Agreements

The contractor shall abide by the following:

- **Verification of Terms -** The contractor shall determine whether: (1) the information contained in the sales/lease agreement is consistent with that reported on the new owner's Form CMS-855A (e.g., same names), and (2) the terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in section 2F is checked "Yes" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should deny the application.

- **Form of Sales/Lease Agreement -** There may be instances where the parties in a CHOW did not sign a “sales” or “lease” agreement in the conventional sense of the term; the parties, for example, may have documented their agreement via a “bill of sale.” The contractor may accept this documentation in lieu of a sales/lease agreement so long as the document furnishes clear verification of the terms of the transaction.

- **Submission of Final Sales/Lease Agreement -** The contractor shall not forward a copy of the application to the State agency until it has received and reviewed the final sales/lease agreement. It need not revalidate the information on the Form CMS-855A, even if the data therein may be somewhat outdated by the time the final agreement is received.

  If a final sales/lease agreement is not submitted within 90 days after the contractor’s receipt of the new owner’s application, the contractor shall reject the application. Though the contractor must wait until the 90$^{th}$ day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were obtained.

Unless specified otherwise in this chapter, both the old and new owners must submit separate Form CMS-855A applications, as well as copies of the interim and final sales/lease agreements.

## E. CHOWs Involving Subunits and Subtypes

Any subunit that has a separate provider agreement (e.g., home health agency (HHA) subunits) must report its CHOW on a separate Form CMS-855A. It cannot report the CHOW via the main provider’s Form CMS-855A. If the subunit has a separate CMS Certification Number (CCN) but not a separate provider agreement

(e.g., hospital psychiatric unit, HHA branch), the CHOW can be disclosed on the main provider's Form CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity.

On occasion, a CHOW may occur in conjunction with a change in the facility's provider subtype. This frequently happens when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), it is not necessary for the provider to submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW. However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.

**NOTE:** For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital that undergoes a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.

### F. Early Submission of CHOW Application

The contractor may accept Form CMS-855A CHOW applications submitted up to 90 calendar days prior to the anticipated date of the ownership change. Any application received more than 90 days before the projected sale date can be returned under section 15.8.1 of this chapter.

### G. Unreported CHOW

If the contractor learns via any means that an enrolled provider has: (1) been purchased by another entity, or (2) purchased another Medicare enrolled provider, the contractor shall immediately request Form CMS-855A applications from both the old and new owners. If the new owner fails to submit a Form CMS-855A within the latter of: (1) the date of acquisition, or (2) 30 days after the request, the contractor shall stop payments to the provider. Payments may be resumed upon receipt of the completed Form CMS-855A.

If the contractor learns of the transaction via the receipt of a tie-in notice from the RO, it shall follow the instructions under "Receipt of Tie-In When CMS-855A Not Completed" in section 15.7.7.2 of this chapter.

### H. Relocation of Entity

A new owner may propose to relocate the provider concurrent with the CHOW. If the relocation is to a site in a different geographic area serving different clients than

previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the provider shall - per CMS Publication 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the provider as a new applicant), rather than as an address change of the existing provider.

**I. Transitioning to Provider-Based Status**

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR §489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the buyer's and seller's Form CMS-855A applications. Should the "old" (or current) contractor receive the buyer's or seller's Form CMS-855A application, it shall: (a) forward the application to the new contractor within 5 business days of receipt, and (b) notify the new contractor within that same timeframe that the application was sent.

## 15.7.7.1.4 - Intervening Change of Ownership (CHOW)

**(Rev. 462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)**

(This section does not apply to home health agencies)

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the CMS Regional Office (RO), the contractor shall abide by the following:

- Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall return both applications and require the provider to re-submit an initial application with the new owner's information.

- Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the State/RO in the same package. The accompanying notice/letter to the State/RO shall explain the situation.

- Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:

- Return the CHOW application.

- Notify the State/RO via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

- Request via letter that the provider submit a new initial CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall return the initial application and notify the provider and the State/RO of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the State/RO with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

- Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

  - Notify the State/RO via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the State/RO with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

## 15.7.7.1.5 – Electronic Funds Transfer (EFT) Payments and CHOWs

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

In a CHOW, the contractor shall continue to pay the Seller/Transferor until it receives the tie-in/approval notice from the RO. Hence, the contractor shall reject any application from the Seller or the Buyer to change the EFT account or special payment address to that of the new owner before receiving the tie-in/approval notice. It is ultimately the responsibility of the Buyer and the Seller to work out any payment arrangements between themselves while the contractor and RO are processing the CHOW. It is advisable that the contractor notify the new owner of this while the application is being processed.

In a CHOW, the existing provider agreement is automatically assigned to the Buyer/Transferee. If the Buyer/Transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will **never** pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the Buyer/Transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

## 15.7.7.1.6 – Pre-Approval Changes of Information

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

**A. Seller**

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a Form CMS-855 request to change any of the provider's enrollment data, the contractor shall reject the change request if the information in question involves changing the provider's:

1. Electronic funds transfer or special payment address information to that of the buyer (as described in section 15.7.7.1.5 of this chapter)

2. Practice location or base of operations to that of the buyer

3. Ownership or managing control to that of the buyer

4. Legal business name, tax identification number, or "doing business as" name to that of the buyer.

All other "pre-tie-in notice" Form CMS-855 change requests from the seller can be processed normally.

**B. Buyer**

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a Form CMS-855 request to change any of the provider's existing enrollment information, the contractor shall reject the change request. Until the tie-in notice is issued, the seller remains the owner of record. Hence, the buyer has no standing to submit Form CMS-855 changes on behalf of the provider.

## 15.7.7.2 - Tie-In/Tie-Out Notices and Referrals to the State/RO

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

**A. Issuance of Tie-In/Tie-Out Notices**

A tie-in or tie-out notice (CMS-2007) is generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

4. Involuntary terminations (e.g., provider no longer meets conditions of participation or coverage) prompted by the state/RO

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

**B. Form CMS-855 Changes of Information, Stock Transfers, and Other Transactions**

**1. Referrals to State/RO**

The following is a list of Form CMS-855A transactions that generally require a recommendation and referral to the state/RO:

- Addition of outpatient physician therapy/outpatient speech pathology extension site

- Addition of hospice satellite

- Addition of home health agency branch

- Change in type of Prospective Payment System (PPS)-exempt unit

- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)

- Change in practice location or subunit address in cases where a survey of the new site is required

- Stock transfer

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

(1) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,

(2) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and

(3) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in (B)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to "approved).

**2. Post-Approval RO Contact Required**

Form CMS-855A changes that do not mandate a recommendation to the state/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or hospital subunits

- Legal business name, tax identification number, or "doing business as name" changes that do not involve a CHOW

- Address changes that do not require a survey of the new location

- Addition of hospital practice location

- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials

- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

For these transactions, the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to "approved." The contractor shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO shall specify the type of information that is changing.

**3. All Other Changes of Information**

For all Form CMS-855A change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the provider via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The state and RO need not be notified of the change.

**4. Revalidations, Reactivations and Complete Form CMS-855 Applications**

In situations where the provider submits a: (1) Form CMS-855A reactivation, (2) Form CMS-855A revalidation, or (3) full Form CMS-855A as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state/RO and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855A, the contractor shall make a recommendation to the state/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state/RO needs to consider is the new hospital unit.

If the application contains new/changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to "approved." It shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

**C. Provider-Specific, Non-CMS-855 Changes**

If the contractor receives a tie-in notice or approval letter from the RO for a transaction/change regarding information that is not collected on the Form CMS-855A, the contractor need not ask the provider to submit a Form CMS-855A change of information.

**D. Involuntary Termination Prompted by State/RO**

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider's Medicare participation because the provider no longer meets the conditions of participation, the contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the provider's/supplier's enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall **not** identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."

In addition, contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar. If CMS learns that the terminated provider plans to receive further surveys during the reasonable assurance period, then CMS will rescind the enrollment bar. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

**E. Other Procedures Related to Tie-In Notices, Tie-Out Notices and Approval Letters**

**1. Receipt of Tie-In When Form CMS-855A Not Completed** - If the contractor receives a tie-in notice or approval letter from the RO but the provider never completed the necessary Form CMS-855A, the contractor shall have the provider complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

**2. Delegation to State Agency –** There may be instances when the RO delegates the task of issuing tie-in notices, tie-out notices or approval letters to the state agency. The contractor may accept such notices from the state in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the state, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

**3. Review for Consistency** - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855A. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

**4. Creation of New Logging and Tracking (L & T) Record Unnecessary** - The contractor is not required to create a new L & T record in PECOS when the tie-in notice arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

**5. Provider Inquiries –** Once the contractor has made its recommendation for approval to the state/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the state or RO.

**6. Timeframes -** So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

## 15.7.7.2.1 – Processing Tie-In Notices/Approval Letters

**(Rev. 433, Issued: 09-07-12, Effective: 10-09, 12, Implementation 10-09-12)**

With respect to Form CMS-855A transactions for which a post-tie-in notice/approval letter site visit is not required (e.g., providers in the "limited" risk category), the contractor shall complete its processing of said notice/letter within 21 calendar days after its receipt of the tie-in/approval notice. For purposes of this requirement, the term "processing" includes all steps taken by the contractor's enrollment and non-enrollment units (e.g. financial area, reimbursement area) to establish the provider's ability to bill Medicare such as, but not limited to:

1. Entering all relevant data into the Provider Enrollment, Chain and Ownership System (PECOS).

2. Changing the provider's PECOS record to the appropriate status (e.g., "approved").

3. Facilitating the provider's electronic funds transfer and electronic data interchange arrangements.

4. Notifying the provider (via any mechanism the contractor chooses) that it may begin billing.

The 21-day period begins on the day that the contractor receives the tie-in notice and ends on the day that the contractor notifies the provider that it can commence billing.

Regarding Form CMS-855A transactions that require a post-tie-in notice/approval letter site visit, the contractor shall process the tie-in notice/letter within 45 calendar days of its receipt of the notice/letter. This is to account for the additional time needed for the site visit to be performed.

## 15.7.7.3 - Reserved for Future Use

**(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)**

## 15.7.7.4 - State Surveys and the Form CMS-855A

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

In general, information on the Form CMS-855A is still considered valid notwithstanding a delay in the State survey. However, the provider must submit an updated Form CMS-855A application to the contractor if:

- The contractor becomes aware of such a delay;
- The delay is the fault of the provider; and
- At least 6 months have passed since the contractor sent its recommendation for approval to the State.

If these criteria are met, the contractor shall send a letter to the provider requesting an updated Form CMS-855A. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the provider may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed Form CMS-855A certification statement.

**NOTE:** If the applicant is a home health agency (HHA), it must resubmit capitalization data per section 12 of the Form CMS-855A regardless of whether any of the provider's other Form CMS-855A information has changed. To illustrate, if no Form CMS-855A data has changed, the HHA must submit the letter, capitalization data and the signed certification statement.

If the provider fails to furnish the requested information within 60 days of the contractor's request, the contractor shall submit a revised letter to the State that recommends denial of the provider's application.

## 15.7.7.5 - Sole Proprietorships

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

If the provider indicates in section 2B1 of the Form CMS-855A that he/she is a sole proprietor, the contractor shall note the following:

- The LBN in section 2B1 should list the person's (the sole proprietor's) legal name.

- The TIN in section 2B1 should list the person's social security number.

- Section 3 of the Form CMS-855A must be completed with information about the individual's final adverse action history.

- Section 5 of the Form CMS-855A will not apply unless the person has hired an entity to exercise managerial control over the business (i.e., no owners will be listed in section 5, as the sole owner has already reported his/her personal information in sections 2 and 3).

- No owners, partners, or directors/officers need to be reported in section 6. However, all managing employees (whether W-2 or not) must be listed.

- The sole proprietor may list multiple authorized or delegated officials in sections 15 and 16.

Since most sole proprietorships that complete the Form CMS-855A will also have an employer identification number (EIN), the contractor shall request from the provider a copy of its CP-575, any federal tax department tickets, or any other preprinted information from the IRS containing the provider's EIN.

## 15.7.7.6 - Additional Form CMS-855A Processing Instructions

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

### A. Non-Enrollment Functions

In some instances, the contractor cannot forward an application to the State until it performs certain non-enrollment functions pertaining to the application (e.g., the reimbursement unit needs to examine patient listing data). The contractor may flip the provider's status in the Provider Enrollment, Chain and Ownership System (PECOS) to "approval recommended" prior to the conclusion of the non-enrollment activity if: (1) all required enrollment actions have been completed, and (2) the non-enrollment action is the only remaining activity to be performed.

**B. Multiple Providers under a Single Tax Identification Number (TIN)**

Multiple providers may have the same TIN. However, each provider must submit a separate Form CMS-855A application and the contractor must create a separate enrollment record for each.

**C. Future Effective Dates**

If the contractor cannot enter an effective date into PECOS because the provider, practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the actual effective date is established (e.g., the tie-in notice is received), the contractor shall change the effective date in PECOS.

## 15.7.7.7 – Contractor Jurisdictional Issues

**(Rev. 492, Issued: 12-06-13, Effective: 01-07-14, Implementation: 01-07-14)**

**A. Audit and Claims Contractors**

1. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per section 15.8.1 of this chapter.

2. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

(a) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS).

Pertinent identifying information, such as the provider name, CMS Certification Number and National Provider Identifier, shall be included in the e-mail notification. Any supporting documentation that contains personal health information or personally identifiable information may still be faxed to the claims contractor.

(b) As applicable, fax or mail a copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall keep all original copies of Form CMS-855A paperwork and supporting documentation, including all Form CMS-588s.

3. Tie-In/Tie-Out Notices and Approval Notices

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all tie-in/tie-out notices and approval letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of tie-in/tie-out notices and approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

**B. Provider Nomination**

With respect to provider nomination and changes of contractors, the contractor shall follow the instructions in Pub. 100-04, chapter 1, sections 20 through 20.5.1.

If the contractor receives a request from a provider to change its existing contractor, it shall refer the provider to the RO contact person responsible for contractor assignments.

## 15.7.8 – Special Processing Guidelines for Independent CLIA Labs, Ambulatory Surgical Centers and Portable X-ray Suppliers

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

Unless otherwise stated, all references to the "RO" in sections 15.7.8.2 through 15.7.8.5 of this chapter refer to the RO's survey & certification staff.

## 15.7.8.3.1 – Examining Whether a CHOW May Have Occurred

**(Rev. 474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)**

**A. Review of Sales Agreement**

If the "Change of Ownership" box in section 1B of the Form CMS-855B is checked, the contractor shall ensure that the entire application is completed and that the supplier submits a copy of the sales agreement. The contractor shall review the sales agreement to determine whether:

1. The ownership change qualifies as a CHOW under the principles of 42 CFR §489.18 and Pub. 100-07, chapter 3, section 3210.1D;

2. Its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner;

3. The information contained in the agreement is consistent with that reported on the new owner's Form CMS-855B (e.g., same names)

If the sales agreement is unclear as to issues 1 and 2 above, the contractor shall request clarifying information from the supplier. (**NOTE:** Some sales agreements may fail to specifically refer to Medicare supplier agreements, assets, and/or liabilities, therefore requiring a close review of the sales agreement in its totality.) The information shall be in the form of additional legal documentation or a letter. If the clarification – for whatever reason - requires an update to the supplier's Form CMS-855B application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the Form CMS-855B (issue 3 above), the contractor shall seek clarifying information and, if necessary, obtain an updated Form CMS-855B.

In reviewing the application and the sales agreement, the contractor shall keep in mind the following:

- There may be instances where the parties in a CHOW did not sign a "sales agreement" in the conventional sense of the term; the parties, for example, may have documented their agreement in a "bill of sale." The contractor may accept this alternative documentation in lieu of a sales agreement so long as the document furnishes clear verification of the terms of the transaction.

- While a CHOW is usually accompanied by a TIN change, this is not always the case; there may be a few instances where the TIN remains the same. Conversely, there may be cases where a supplier is changing its TIN but not its ownership. So while a change of TIN (or lack thereof) is evidence that a CHOW has or has not occurred, it is not the most important factor; rather, the change in the provider's ownership structure is.

- Form CMS-855B CHOW applications may be accepted by the contractor up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than 3 months in advance of the projected sale date shall be returned under section 15.8.1 of this chapter.

- On occasion, an ASC or PXRS may submit a Form CMS-855B change of information to report a large-scale stock transfer or other significant ownership change that the supplier does not believe qualifies as a CHOW. If the contractor has any reason to suspect that the transaction in question may indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the RO for guidance. Such referrals to the RO should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment has taken place and should not be made as a matter of course. A RO CHOW determination is usually not required prior to the contractor making its recommendation.

**B. Processing Steps**

After performing the steps identified in subsection (A) above, the contractor shall abide by the following:

1. If the contractor believes that a CHOW has occurred but the new owner is not accepting the assets and liabilities of the old owner, the contractor shall treat the ASC/PXRS as a brand new supplier. It shall notify the ASC/PXRS that it must submit: (1) a Form CMS-855B voluntary termination to terminate the "old" facility, and (2) a Form CMS-855B initial enrollment for the "new" facility.

2. If the contractor believes that a CHOW has taken place and that the new owner is accepting the old owner's assets and liabilities, it shall process the application normally and make a recommendation for approval to the State (with a cc: to the RO) or, if applicable, issue a denial. If the valid CHOW/acceptance of assignment was accompanied by a change in TIN, the transaction must be treated as a CHOW notwithstanding the general rule that a TIN change constitutes an initial enrollment. In other words, the reporting rules regarding CHOWs/assignments in this particular situation take precedence over the "change of TIN" principle.

3. If the contractor believes that a CHOW has not occurred and that the transaction merely represents an ownership change (e.g., minor stock transfer) that does not qualify as a 42 CFR §489.18-type CHOW, the transaction must be reported as a change of information. The only exception to this is if the change of information was accompanied by a change of TIN, in which case the supplier must enroll as a new entity.

**NOTE:** It is not uncommon for a supplier to undergo a financial or administrative change that it considers to be a CHOW but in actuality does not meet the regulatory definition identified in §489.18.

In scenario 2 above, the contractor shall not forward a copy of the CHOW application to the State agency until it has received and reviewed the final sales agreement. (In some cases, the supplier may submit an interim sales agreement with its application; this is acceptable, so long as it submits the final agreement in accordance with these instructions.) If the final sales agreement is not submitted within 90 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 90th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what type of responses (short of the actual receipt of the sales agreement) were obtained.

### C. Entry into the Provider Enrollment, Chain and Ownership System (PECOS)

If it appears that the new owner will be accepting assignment as well as the assets and liabilities of the old owner, the contractor shall enter the changed data into the old owner's enrollment record in PECOS and, if applicable, switch the record to an "Approval Pending Regional Office Review" status. A new enrollment record shall not be created. If the RO approves the CHOW and sends the tie-in/approval notice to the contractor, the supplier's CMS Certification Number (CCN) will be maintained and the information in the existing record will be updated to reflect the new owner's information once the record is switched to an approved status.

If it appears that the new owner will not be accepting assignment as well as the assets and liabilities of the old owner, a new enrollment record shall be created containing the new owner's information.

### D. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the supplier shall - per Pub. 100-07, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

## 15.7.8.3.2 – Electronic Funds Transfer (EFT) Payments and CHOWs

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

In a CHOW, the contractor shall continue to pay the old owner until it receives the

tie-in/approval notice from the RO. Thus, any application from the old or new owner to change the EFT account or special payment address to that of the new owner shall be rejected. It is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the contractor and RO are processing the CHOW. It is advisable that the contractor notify the supplier of this while the application is being processed.

If – pursuant to the CHOW – the seller submits a Form CMS-855B voluntary termination application, the contractor shall contact and explain to the seller that the ambulatory surgical center/portable x-ray supplier will not receive any payments until the RO approves the CHOW. (This is because payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process it; however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective.

## 15.7.8.4 - Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO

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

(For purposes of this section 15.7.8.4, the terms "tie-in notices" and approval letters will be collectively referred to as tie-in notices. "Tie-out notices" are notices from the RO to the contractor that, in effect, state that the ASC's/PXRS's participation in Medicare should be terminated.)

### A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice is generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

4. Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the state/RO.

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the state/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

## B. Form CMS-855B Changes of Information, Stock Transfers, and Other Transactions

### 1. Referrals to State/RO

The following is a list of transactions that require a recommendation and referral to the state/RO:

- Addition of practice location
- Stock transfer
- Change in practice location or address in cases where a survey of the new site is required

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the transaction. However, if the contractor knows that the particular state/RO in question typically does not review, approve, or deny this type of transaction, the contractor need not send the transaction to the state/RO for approval and shall instead follow the instructions in (B)(2) below.

(If the transaction is a stock transfer, the contractor need not send the transaction to the state/RO for approval (and shall instead follow the instructions in (B)(2) below) if the following three conditions are met:

(1) The contractor is confident that the transaction is merely a transfer of stock and not a CHOW,

(2) The RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs, and

(3) The contractor knows that the particular state/RO in question does not review, approve, or deny this type of transaction.

If any of these 3 conditions are not met, the contractor shall send the transaction to the state/RO for approval.)

RO approval for the transactions listed in (B)(1) may be furnished to the contractor via tie-in notice, letter, e-mail, fax, or even telephone; the contractor may accept any of these formats.

If the RO (after receiving the transaction from the contractor for review) notifies the contractor that it does not normally review/approve/deny such transactions, the contractor may finalize the transaction (e.g., switch the PECOS record to

"approved).

**2. Post-Approval RO Contact Required**

Changes that do not mandate a recommendation to the state/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or subunits

- Legal business name, tax identification number or "doing business as" name changes that do not constitute a CHOW

- Address changes that do not require a survey of the new location

- The transactions (excluding stock transfers) described in (B)(1) for which the contractor knows that the state/RO does not issue approvals/denials

- Stock transfers for which the 3 conditions mentioned in (B)(1) are met.

For these transactions, the contractor shall: (1) notify the supplier via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to "approved." The contractor shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. The notice to the state/RO shall specify the type of information that is changing.

**3. All Other Changes of Information**

For all Form CMS-855B change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the supplier via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The state and RO need not be notified of the change.

**4. Revalidations, Reactivations and Complete CMS-855 Applications**

In situations where the provider submits a: (1) Form CMS-855B reactivation, (2) Form CMS-855B revalidation, or (3) full Form CMS-855B as part of a change of information (i.e., the supplier has no enrollment record in PECOS), the contractor shall make a recommendation to the state/RO and switch the record to "approval recommended" only if the application contains new/changed data falling within one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new practice location that was never reported to CMS via the Form CMS-855B, the contractor shall make a recommendation to the state/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward the application to the state with a note explaining that the only

matter the state/RO needs to consider is the new location.

If the application contains changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to "approved." The contractor shall also notify the state and RO of the changed information (via any mechanism it chooses, including copying the state/RO on the notification letter or e-mail) no later than 10 days after it has completed processing the transaction.

**C. Supplier-Specific, Non-CMS-855 Changes**

If the contractor receives a tie-in notice or approval letter for a transaction that concerns information not collected on the Form CMS-855B application, the contractor need not ask the supplier to submit a Form CMS-855B change of information.

**D. Involuntary Termination Prompted by State/RO**

If the contractor receives a tie-out notice from the RO that involuntarily terminates the supplier's Medicare participation because the supplier no longer meets the conditions of coverage, the contractor shall adhere to the instructions in section 15.27.2 of this chapter with respect to revoking the supplier's enrollment, as the supplier is no longer in compliance with Medicare enrollment regulations.

The revocation shall be recorded in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." Contractors shall **not** identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program."

In addition, contractors shall enter the appropriate enrollment bar and issue a revocation letter to the certified provider or supplier using 42 CFR §424.535(a)(1), as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights and the length of the enrollment bar. If CMS learns that the terminated provider plans to receive further surveys during the reasonable assurance period, then CMS will rescind the enrollment bar. The issuance of the Tie-Out for non-compliance of CMS enrollment requirements, conditions of participation, or conditions of coverage is sufficient to revoke.

**E. Other Procedures Related to Tie-In/Tie-Out Notices and Approval Letters**

**1. Receipt of Tie-In When Form CMS-855B Not Completed**

If the contractor receives a tie-in notice or approval letter from the RO but the supplier never completed the necessary Form CMS-855B, the contractor shall have the supplier complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

**2. Delegation to State Agency –** There may be instances when the RO delegates the task of issuing tie-in notices, tie-out notices or approval letters to the state agency. The contractor may accept such notices from the state in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the state, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

**3. Review for Consistency**

When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855B. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

**4. Creation of New Logging and Tracking (L & T) Record Unnecessary**

The contractor is not required to create a new L & T record in PECOS when the tie-in notice or approval letter arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

**5. Supplier Inquiries**

Once the contractor makes its recommendation for approval to the state/RO, any inquiry the contractor receives from the supplier regarding the status of its request for Medicare participation shall be referred to the state or RO.

**6. Timeframes**

So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

## 15.7.8.5 – Reserved for Future Use

**(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)**

## 15.7.8.6 - State Surveys and the Form CMS-855B

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

**A. Delay in State Survey**

In general, information on the Form CMS-855B is still considered valid notwithstanding a delay in the State survey. However, the supplier must submit an

updated Form CMS-855B application to the contractor if:

- The contractor becomes aware of such a delay;
- The delay is the fault of the supplier; and
- At least 6 months have passed since the contractor sent its recommendation for approval to the State.

If these criteria are met, the contractor shall send a letter to the supplier requesting an updated Form CMS-855B. The application must contain, at a minimum, any information that is new or has changed since the recommendation for approval was made, as well as a newly-signed certification statement. If no information has changed, the supplier may instead submit: (1) a letter on its business letterhead stating as such, and (2) a newly-signed Form CMS-855B certification statement.

If the supplier fails to furnish the requested information within 60 calendar days, the contractor shall submit a revised letter to the State that recommends denial of the supplier's application.

**B. Future Effective Dates**

If the contractor cannot enter an effective date into PECOS because the supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider and the effective date is established (e.g., the tie-in notice is received), the contractor shall change the effective date in PECOS.

## 15.7.9 – Indirect Payment Procedure

**(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)**

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity under the indirect payment procedure (IPP). Sections 15.7.9.1 through 15.7.9.7 below outline the IPP registration process.

## 15.7.9.1 – Indirect Payment Procedure - Background

**(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)**

Per 42 CFR § 424.66(a), Medicare may pay an entity for Part B services furnished by a physician or other supplier if said entity meets all of the following requirements:

(1) Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits

and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

(2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

(3) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his/her behalf under 42 CFR § 424.36) to receive the Part B payment for the services for which the entity pays.

(4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his/her survivors, or estate.

(5) Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that comply with § 424.66(a) and the registration procedures described in sections 15.7.9.1 through 15.7.9.7 of this chapter are hereinafter referred to as “IPP entities.” An IPP entity is not a “provider” or “supplier” as those terms are defined in § 400.202; moreover, an IPP entity does not meet the definition of a “health care provider” under 45 CFR § 160.103 and, as such, is not eligible for a National Provider Identifier (NPI). Indeed, an IPP entity does not furnish Medicare services. Rather, it is an entity that provides supplementary coverage in the circumstances described in §424.66(a). To illustrate, suppose an IPP entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims. Assuming, again, that all requirements are met, entities that may utilize the IPP could include:

- Employers
- Unions
- Insurance companies
- Retirement homes
- Health care prepayment plans
- Health maintenance organizations
- Competitive medical plans
- Medicare Advantage plans

As stated, an IPP entity is not a Medicare provider or supplier. It therefore cannot enroll in the Medicare program. It is crucial, nonetheless, that Medicare obtain sufficient background information on prospective IPP entities to ensure the

integrity, accuracy, and legitimacy of Medicare payments to said entities. Hence, CMS will apply the Form CMS-855 process to IPP entities consistent with our authority to request information under 42 CFR § 424.66(a)(5). For purposes of the IPP, this process is called IPP "registration," rather than enrollment. An entity must satisfy the requirements described in 42 CFR § 424.66 and successfully complete the Form CMS-855 registration process before it can bill Medicare under the IPP. Naturally, an IPP entity's status as a non-provider and non-supplier will result in procedures that differ in certain aspects from those associated with the enrollment of Medicare providers and suppliers.

## 15.7.9.2 - Submission of Registration Applications

**(Rev. 590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)**

**A. Jurisdiction**

An IPP entity's registration application must be submitted to each Medicare claims administration contractor to which the IPP entity will be submitting claims. Claims for all Part B items and services – other than for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – must be submitted to the A/B Medicare Administrative Contractor (MAC) or carrier based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides. However, claims for Medicare-covered implantable devices, although classified as DME, are submitted to the A/B MACs or carriers based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to submission of registration applications. As such, the IPP entity must complete and submit:

(1) Form CMS-855C and Form CMS-588 to each applicable A/B MAC to which the plan will be submitting its non-DMEPOS claims; and/or

(2) Form CMS-855C and Form CMS-588 to the National Supplier Clearinghouse (NSC).

With respect to (1) – and consistent with section 15.5.4.2(D) of this chapter - the IPP entity need only submit one Form CMS-855C application and one Form CMS-588 per contractor jurisdiction.

**B. Form Completion**

The IPP entity:

(1) Must use the paper version of the Form CMS-855 application.

(2) Must – in light of its ineligibility for an NPI - apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) in accordance with 45 CFR §162. This is to facilitate the entity's submission of claims under the IPP. The entity must furnish its HPID or OEID in the appropriate place on the Form CMS-855. It shall

also list the HPID or OEID on the Form CMS-855 and Form CMS-588 and furnish documentation evidencing the issuance of the number (e.g., a notice from the HPID or OEID issuer identifying the number).

(3) Need not submit licensure or certification information.

(4) Shall list its main business address (e.g., its headquarters) and resident agent address (if applicable) as practice locations.

(5) Need not report medical record storage information.

(6) Need not pay an application fee (as it is not an "institutional provider" under 42 CFR §424.502), although it must receive payments via electronic funds transfer (EFT).

(7) Need not submit a Form CMS-460. Because §1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" at § 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. The IPP entity shall therefore be treated as "non-participating."

(8) Need not meet the applicable (a) supplier standards, (b) accreditation requirements, (c) surety bond requirements, and (d) liability insurance requirements if the IPP entity is a DMEPOS supplier. (The NSC may need to relax certain edits in the Provider Enrollment, Chain and Ownership System (PECOS).) Moreover, the contractor need not perform a site visit.

(9) Meet the attestation requirements in subsection (C) below.

## C. Attestation

1. Contents

The IPP entity must submit with each registration application a signed attestation statement certifying that for each claim it submits, all of the following requirements in 42 CFR §424.66 are met:

(1) The entity provides coverage of the service under a complementary health benefit plan and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan.

(2) The entity has paid the person (i.e., the physician or other supplier) who provided the service (including the amount payable under the Medicare program) an amount that the physician or other supplier accepts as full payment.

(3) The entity has the written authorization of the beneficiary (or other person authorized to sign claims on the beneficiary's behalf under 42 CFR §424.36) to receive the Part B payment for the services paid by the entity.

(4) The entity relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, the beneficiary's survivors, or the beneficiary's estate.

(5) The entity agrees to submit any information requested by CMS or by a Medicare contractor, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) The entity agrees to identify and exclude from its requests for payment all services for which Medicare is the secondary payer.

This attestation is necessary to help ensure that the entity is in compliance with the provisions of §424.66. As already stated, compliance with § 424.66 is a prerequisite for initial and continued registration as an IPP entity.

Since the IPP entity may be submitting applications in multiple jurisdictions, it is acceptable for the entity to submit a photocopy of a signed attestation rather than an originally signed attestation.

2. Signature

An "authorized official" - as that term is defined in 42 CFR §424.502 – must sign all attestations, though the same authorized official need not sign all attestations.

The certification statement on the Form CMS-855C supplements - and does not supplant - the attestation referred to above. The IPP entity is bound by the terms of the certification statement to the same extent as it is bound by the attestation's terms.

## 15.7.9.3 – Processing of Registration Applications

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

### A. Basic Requirements

Upon receipt of a Form CMS-855C registration application from an IPP entity, the contractor shall begin processing the application. This includes:

- Ensuring that the application is complete (see section D(1) below for additional information).

- Creating a logging & tracking (L & T) record and entering the IPP entity's information in the Provider Enrollment, Chain and Ownership System (PECOS).

- Verifying the information on the application in accordance with (1) the "limited" category of screening (see section 15.19.2.1(A) of this chapter for more information), and (2) existing processing guidelines (e.g., reviewing all entities and

individuals listed on the Form CMS-855 against the Medicare Exclusion Database and SAM.

- Ensuring that the attestation identified in section 15.7.9.2 above is submitted, signed by an authorized official, and contains the required language.

- As needed, asking the entity for additional or clarifying information using the procedures outlined in this chapter and other applicable CMS directives; this may include information – beyond the attestation itself – that is necessary to determine whether the entity is indeed in compliance with the provisions of 42 CFR §424.66.

- Assigning specialty code C2.

- Assigning a Provider Transaction Access Number (PTAN) (if the application is approved).

**B. Prescreening**

The contractor need not "prescreen" (as that term is described in section 15.7.1.1 of this chapter) the registration application.

**C. Returns**

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855C. If the contractor determines that one or more of these reasons applies, it shall return the registration application in accordance with the instructions outlined in that section.

**D. Development Issues**

If, in response to a development request, the IPP entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance.

**E. Timeliness and Accuracy Standards**

The timeliness and accuracy standards in sections 15.6.1.1.3, 15.6.1.2, 15.6.2.1, and 15.6.2.2 of this chapter apply to the processing of IPP initial applications and changes of information. Should the contractor exceed timeliness standards due to the requirements of sections 15.7.9.1 through 15.7.9.7, the contractor shall note the provider file in accordance with section 15.7.3 of this chapter.

**F. HPID/OEID**

The algorithm for the HPID/OEID is similar to that of the National Provider Identifier in that it will be 10 digits in length and will begin with either a "7" (HPID) or a "6" (OEID). The HPID/OEID will replace the placeholder NPI for IPP entities only.

## 15.7.9.4 – Disposition of Registration Applications

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

### A. Approval

If the contractor determines that the IPP entity meets all necessary requirements, it shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable) and HPID or OEID; (2) a draft approval letter patterned after the applicable model letter in section 15.7.9.7; and (3) any issues the contractor encountered in its review. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

If PEOG authorizes the approval, the contractor shall (1) switch the Provider Enrollment, Chain and Ownership System (PECOS) record to "Approved," (2) establish an effective date that is the date on which the contractor approved the application, (3) assign a Provider Transaction Access Number (PTAN) or National Supplier Clearinghouse number (as applicable), and (4) send the approval letter via regular mail or e-mail to the entity no later than 3 business days after the contractor received authorization of the approval from PEOG.

After the entity is registered, the contractor (consistent with § 424.66(a)(5)) should request additional information in order to confirm the entity's continued compliance with 42 CFR §424.66.

### B. Denial

If the contractor determines that the entity does not meet all necessary requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft denial letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor's rationale for proposing to deny the application. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for denial include, but are not limited to, the following:

(1) The entity does not comply with all applicable registration requirements.

(2) The entity does not satisfy all of the requirements described in 42 CFR §424.66. (The contractor can contact its PEOG BFL for assistance on this issue.)

(3) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and the SAM.

If the contractor believes that any other ground for denial exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the denial, the contractor shall (1) switch the PECOS record to "Denied," and (2) send the denial letter via certified mail to the entity no later than 3 business days after the contractor received authorization of the denial from PEOG.

As indicated in the model denial letter in section 15.7.9.7, an entity should appeal the denial of its IPP registration application. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

**C. Rejection**

The Form CMS-855 shall be rejected if (1) the entity fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so (of the date of the request, as noted in section 15.8.2 and the examples found in section 15.7.1.5), or (2) the entity fails to timely submit new or corrected information in the scenarios described in section 15.8.2 of this chapter. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR §424.525(a). The rejection letter shall follow the format of the applicable letter in section 15.7.9.7 and shall be sent via regular mail no later than 5 business days after the contractor determines that the application should be rejected.

Prior PEOG approval of the rejection is unnecessary. However, as stated earlier, if the entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its PEOG BFL for guidance.

## 15.7.9.5 – Revocation of Registration

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

If the contractor determines that the entity no longer meets all necessary requirements, it shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft revocation letter patterned after the applicable model letter in section 15.7.9.7 below; and (3) the contractor's rationale for proposing to revoke the entity's registration. The PEOG BFL will review the matter and advise the contractor as to

how to proceed.

Grounds for revocation include, but are not limited to, the following:

(1) The entity no longer complies with all applicable registration requirements.

(2) The entity no longer appears to be in compliance with the provisions of 42 CFR §424.66. (The contractor can contact its PEOG BFL for assistance regarding grounds (1) and (2).)

(3) The entity has not complied with the terms of its signed Form CMS-855 certification statement (e.g., has not timely submitted an update to its registration information).

(4) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and/or the SAM..

If the contractor believes that any other ground for revocation exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the revocation, the contractor shall (1) switch the PECOS record to "Revoked," and (2) send the revocation letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the revocation from PEOG.

As indicated in the model revocation letter in section 15.7.9.7 below, an entity may appeal the revocation of its IPP registration. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

## 15.7.9.6 – Changes of Information and Other Registration Transactions

**(Rev. 590, Issued: 04-24-15, Effective: 05-25-15, Implementation: 05-25-15)**

### A. Changes of Information

An IPP entity is required to submit changes to its Form CMS-855C information in accordance with the terms of its signed Form CMS-855C certification statement. The contractor shall process such changes in accordance with existing instructions.

### B. Other Transactions

1. Deactivations – The contractor shall not deactivate an entity's IPP registration

for any reason unless CMS instructs the contractor to do so.

2. Voluntary Terminations – If an IPP entity submits a voluntary termination application, the contractor shall process it in accordance with existing instructions.

## 15.7.9.7 – Registration Letters

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

The contractor shall use the following letters when approving, denying, or rejecting an application, or when revoking an entity's registration.

**A. Approval**

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & zip code]

Dear [Entity name]:

We are pleased to inform you that your Medicare Form CMS-855C registration application as an Indirect Payment Procedure (IPP) entity has been approved. Listed below is the information reflected in your Medicare Form CMS-855C record, including your Provider Transaction Access Number (PTAN).

For more information on how to bill Medicare, please contact our XXXXXXXX department at [insert phone number].

Your PTAN is also activated for use and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other related transactions. Please keep your PTAN secure.

Medicare Information

| | |
|---|---|
| Entity name: | [Insert name] |
| Business address: | [Insert address] |
| PTAN: | [Insert PTAN] |
| Status: | IPP Entity |

Please verify the accuracy of this information. If you disagree with this initial

determination or have any questions regarding the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation].

Consistent with 42 CFR §424.516, you must submit updates and changes to your Form CMS-855C information in accordance with specified timeframes. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) business address, and (3) payment information (such as changes in electronic funds transfer information). To download the CMS-855 applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at [insert Web site address] or the Centers for Medicare & Medicaid Services' (CMS) Web site at http://www.cms.hhs.gov/home/medicare.asp.

Sincerely,

[Your Name]
[Title]

**B. Denial**

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]
[Address]
[City, State & zip code]

RE: [insert decision]

Dear [Entity name]:

We have received and reviewed your Form CMS-855C registration application as an Indirect Payment Procedure (IPP) entity. Your application is denied. We have determined that you do not meet the conditions necessary to bill Medicare as an IPP entity.

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory

authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to bill Medicare as an IPP entity, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with the necessary registration requirements and must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Mail Stop AR-18-50
7500 Security Boulevard
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
Mail Stop AR-18-50
7500 Security Boulevard
Baltimore, MD 21244-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

**C. Rejection**

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & ZIP Code]

Dear [Entity name]:

We received your Medicare Form CMS-855C registration application on [insert date]. We are rejecting your application and returning it to you for the following reason(s):

FACTS: [Insert ALL rejection reason(s) and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

Consistent with 42 CFR §424.525, prospective Indirect Payment Procedure (IPP) entities are required to submit a complete registration application and all necessary supporting documentation within 30 calendar days from the date of the contractor's request for missing/incomplete/clarifying information. If you would like to resubmit your registration application, please make sure to address the issues stated above and to sign and date the new certification statement page on your resubmitted application.

To submit a new registration application, you may download and complete the application from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.

You should return the complete application to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

**D. Revocation**

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]
[Address]
[City, State & ZIP Code]

[RE: ]

Dear [Entity name]:

This is to inform you that your Medicare registration as an Indirect Payment Procedure (IPP) entity is being revoked effective [insert effective date of revocation].

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and re-establish your eligibility to be registered as an IPP entity, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with all registration requirements. The CAP request must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

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

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request

for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. . Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the revocation involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

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

Consistent with 42 CFR §424.535(c), [insert contractor name] is establishing a re-registration bar for a period of [insert amount of time]. This bar only applies to your registration in the Medicare program. In order to re-register, you must meet all registration requirements.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

## 15.10.2 - Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers

**(Rev. 882; Issued: 05-24-19; Effective: 06-25-19; Implementation: 06-25-19)**

### A. Timeframe for Regional Office (RO) Approval

In situations where RO approval of the change of information is required, it is strongly recommended that the contractor advise the provider that it may take 6 months (or longer) for the request to be approved. The manner and timing in which this information is relayed lies solely within the contractor's discretion.

### B. Post-Recommendation Changes

If an applicant submits a change request after the contractor makes a recommendation on the provider's initial CMS-855 application but before the RO

issues a tie-in/approval notice, the contractor shall process the newly-submitted data as a separate change of information; it shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the State/RO to be incorporated into the existing application. The contractor, however, need not enter the change request into the Provider Enrollment, Chain and Ownership System (PECOS) until the tie-in notice is issued.

In entering the change request into PECOS, the contractor shall use the date it received the change request in its mailroom as the actual receipt date in PECOS; the date the tie-in notice was issued shall not be used. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.

**C. Hospital Addition of Practice Location**

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

**D. Recommendation Before New HHA Location Established**

If an HHA is adding a branch or changing the location of its main location or an existing branch, the contractor may make a recommendation for approval to the State/RO prior to the establishment of the new/changed location (notwithstanding any other instruction in this chapter to the contrary). If the contractor opts to make such a recommendation prior to the establishment of the new/changed location, it shall note in its recommendation letter that the HHA location has not yet moved or been established.

**E. Critical Access Hospital (CAH) Addition of a New Provider-Based Location**

1. Regulations found at 42 CFR 485.610(e)(2) and in the State Operations Manual (SOM), Pub. 100-07, Chapter 2, Section 2256H state that the CAH's provider-based location must meet certain distance requirements from the main campus of another hospital or CAH.

   The MAC shall reach out to the appropriate CMS Regional Office (RO) Division of Survey and Certification (DSC) during the processing of the CMS-855A for a verification that the CAH's new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main campus of another hospital or CAH. The MAC's recommendation of approval cannot be made without receiving a response from the RO DSC.

   If the RO DSC finds that CAH's new provider-based location meets the distance requirements, the RO DSC will send a response to the MAC stating

this. When this communication is received, the MAC shall continue processing as usual, up through issuing a recommendation of approval to the appropriate RO and/or State Agency (SA).

If the RO DSC responds that the new provider-based location does not meet the distance regulations, the MAC shall issue the rejection letter found below to CAH. The enrollment shall remain in an Approved status in PECOS.

The CAH will be provided three options by the RO DSC if it does not meet the distance requirements:

a) The CAH keeps the new provider-based location, which will cause an involuntary termination in 90 days (as outlined in the State Operations Manual, Pub. 100-07, Chapter 3, Section 3012).
b) The CAH will terminate the new provider-based location and continue their enrollment as a CAH.
c) The CAH keeps the new provider-based location, but converts to a hospital (as outlined in the State Operations Manual, Pub. 100-07, Chapter 2, Sections 2256G and 2256H).

For each of these options, the MAC will keep the CAH's enrollment in an approved status in PECOS. In the case of option (a) above, the MAC will receive a tie-out notice for termination, which will lead to revocation of the CAH's enrollment. For option (b), the CAH's enrollment remains approved and the MAC shall expect no further communication from the RO DSC. If the CAH chooses option (c) to convert to a hospital, the MAC will receive a CMS-855A to terminate the CAH's enrollment and a new CMS-855A to enroll as a hospital.

2. [month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) to add a new provider-based location to your Critical Access Hospital enrollment on [date]. We are rejecting your application because the CMS Regional Office, Division of Survey and Certification (RO DSC) has found that your new

location does not meet distance requirements found in 42 CFR 485.610(e)(2).

Please refer to communications from the RO DSC for instructions for your next steps regarding the new provider-based location.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.11 – Electronic Fund Transfers (EFT)

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

### A. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 or Form CMS-20134 before the contractor can effectuate the change.

With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data. Under 42 CFR §424.510(d)(2)(iv) and §424.510(e):

- All providers (including Federal, State and local governments) enrolling in Medicare must use EFT in order to receive payments. Moreover, any provider not currently on EFT that (1) submits any change to its existing enrollment data or (2) submits a revalidation application must also submit a Form CMS-588 and thereafter receive payments via EFT.

- If a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must continue to receive payments via EFT. However, the change in contractors does not require the provider to submit a new Form CMS-588 unless CMS states otherwise.

- For web-based application submissions, the Form CMS-588 shall be submitted via PECOS upload functionality.

**B. Verification**

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

- The information submitted on the Form CMS-588 is complete and accurate.

- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

- The routing number and account number matches what was provided on the Form CMS-588.

- The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or via PECOS upload functionality).

- If the Form CMS-588 is received and is missing the checkbox for the Social Security Number (SSN) or Employer Identification Number (EIN), but the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the application, the contractor may proceed without development back to the provider or supplier.

Once the Form CMS-588 has been processed, the 588 form will be printed and delivered to the contractor's financial area along with the voided check and letter from the bank verifying account information, for proper processing of the EFT information. If this information cannot be verified and the provider fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855 or Form CMS-20134.

**C. Miscellaneous Policies**

**1. Banking Institutions** - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider's bank of choice does not or will not participate in the provider's proposed EFT arrangement, the provider must select another financial institution.

**2. Verification** - The contractor shall ensure that all EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.

**3. Sent to the Wrong Unit** - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall

forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 or Form CMS-20134 in the file.

**4. Bankruptcies and Garnishments** – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel.

**5. Closure of Bank Account** – If a provider has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider on payment withhold until an EFT agreement (and Form CMS-855 or Form CMS-20134, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence deactivation procedures in accordance with the instructions in this chapter. The basis for deactivation would be §424.540(a)(2) due to the provider's failure to comply with the EFT requirements outlined in §424.510(e)(1) and (e)(2).

**6. Reassignments** – If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

**7. Final Payments** – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider's EFT account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855, or Form CMS-20134, Form CMS-588 request identifying where it wants payments to be sent.

**8. Chain Organizations -** Per CMS Publication 100-04, chapter 1, section 30.2, a Part A chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted. If any of the chain

providers have never completed a Form CMS-855A, they must do so at that time.

## 15.12 – Reserved for Future Use

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

## 15.13 – Existing or Delinquent Overpayments

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

Consistent with 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502) of the applying provider or supplier, or (2) the applying physician or non-physician practitioner, has an existing overpayment that is equal to or exceeds a threshold of $1,500 and it has not been repaid in full at the time the application was filed. To this end, the contractor shall:

- When processing a Form CMS-855A, CMS-855B, CMS-855S, or CMS-20134 initial or change of ownership application, determine – using a system generated daily listing - whether any of the owners listed in section 5 or 6 of the application has an existing or delinquent Medicare overpayment.

- When processing a Form CMS-855I initial application, determine – using a system generated daily listing - whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term "non-physician practitioner" includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.)

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior approval from CMS' Provider Enrollment & Oversight Group (PEOG) is required before proceeding with the denial. The contractor shall under no circumstances deny an application under §424.530(a)(6) without receiving PEOG approval to do so.

Consider the following examples:

Example #1: Hospital X has a $200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new Form CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare

enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the $50,000 overpayment was attached to him as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the $50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a Form CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

**NOTE:** The contractors shall also observe the following:

- In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.

- The instructions in this section 15.8.4 apply only to (1) initial enrollments, and (2) new owners in a change of ownership.

The term "owner" under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)

- If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 15.8.4, the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

## 15.14 – Special Processing Situations

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

## 15.14.1 – Non-CMS-855 and non-CMS-20134 Enrollment Activities

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

There are situations where the contractor processes non-CMS-855 forms, Form CMS-20134, and other documentation relating to provider enrollment. Such activities include:

- EFT agreements (Form CMS-588) submitted alone
- "Do Not Forward" issues
- Par agreements (Form CMS-460)
- Returned remittance notices
- Informational letters received from other contractors
- Diabetes self-management notices
- Verification of new billing services
- Paramedic intercept contracts
- 1099 issues that need to be resolved

Unless specified otherwise in this chapter or another CMS directive, the contractor shall not create a logging and tracking record for any non-CMS-855 or non-CMS-20134 document or activity other than the processing of par agreements. The contractor should track and record all other activities internally.

## 15.14.2 – Contractor Communications

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

Medicare contractors create Associate and Enrollment Records in the Provider Enrollment, Chain and Ownership System (PECOS). Ownership of an Associate or Enrollment Record belongs to the contractor within whose jurisdiction the provider/supplier is located. PECOS only permits the contractor that created the Associate or Enrollment Record (the “owning contractor”) to make updates, changes, or corrections to those records. (That is, the owning contractor is the only contractor that can make changes to the associate record.)
Occasionally, updates, changes, or corrections do not come to the owning contractor’s attention, but instead go to a different contractor. In those situations, the contractor that has been notified of the update/change/correction (the “requesting” contractor) must convey the changed information to the owning contractor so that the latter can update the record in PECOS.

The requesting contractor may notify the owning contractor via fax of the need to update/change/correct information in a provider’s PECOS record. The notification must contain:

1. The provider's legal business name, Provider Transaction Access Number, and National Provider Identifier; and

2. The updated/changed/corrected data (by including a copy of the appropriate section of the Form CMS-855 or Form CMS-20134).

Within 7 calendar days of receiving the requesting contractor's request for a change to a PECOS record, the owning contractor shall make the change and notify the requesting contractor thereof via fax, e-mail, or telephone.

If the owning contractor is reluctant to make the change, it shall contact its CMS Provider Enrollment & Oversight Group (PEOG) liaison for guidance. Note that the owning contractor may ask the requesting contractor for any additional information about the provider it deems necessary (e.g., IRS documentation, licenses).

The owning contractor need not ask the provider for a Form CMS-855 or Form CMS-20134 change of information in associate profile situations. It can simply use the Form CMS-855 copy that the requesting contractor sent/faxed to the owning contractor. For instance, suppose Provider X is enrolled in two different contractor jurisdictions – A and B. The provider enrolled with "A" first; its legal business name was listed as "John Brian Smith Hospital." It later enrolls with "B" as "John Bryan Smith Hospital." "B" has verified that "John Bryan Smith Hospital" is the correct name and sends a request to "A" to fix the name. "A" is not required to ask the provider to submit a Form CMS-855A change of information. It can use the CMS-855A copy that it received from "B."

## 15.14.3 – Provider-Based

**(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)**

The contractor shall adhere to the following regarding the enrollment of provider-based entities:

- **Certified Provider or Certified Supplier Initially Enrolling –** Suppose an HHA or other certified provider or certified supplier wishes to enroll and become provider-based to a hospital. The provider/supplier must enroll with the contractor as a separate entity. It cannot be listed as a practice location on the hospital's Form CMS-855A.

- **Certified Provider or Certified Supplier Changing its Provider-Based Status –** If a certified provider or certified supplier is changing its status from provider-based to freestanding or vice versa, it need not submit any updates to its Form CMS-855 enrollment.

- **Group Practice Initially Enrolling –** If a group practice is enrolling in Medicare and will become provider-based to a hospital, the group generally must enroll via the Form CMS-855B if it wants to bill for practitioner services. The group would also need to be listed or added as a practice location on the hospital's Form CMS-855A.

- **Group Practice Changing from Provider-Based to Freestanding** – In this situation, the hospital should submit a Form CMS-855A change request that deletes the clinic as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.

- **Group Practice Changing from Freestanding to Provider-Based** – Here, the hospital must submit a Form CMS-855A change request adding the group as a practice location. The group may also need to change the type of clinic it is enrolled as; this may require a new Form CMS-855B.

Unless the CMS regional office (RO) dictates otherwise, the contractor shall not delay the processing of any practice location addition applications pending receipt of provider-based attestations or RO approval of provider-based status.

## 15.14.6 – Participation (Par) Agreements and the Acceptance of Assignment

**(Rev. 592, 05-08-15, Effective: 06-08-15, Implementation: 06-08-15)**

## 15.14.6.1 – General Information

**(Rev. 592, 05-08-15, Effective: 06-08-15, Implementation: 06-08-15)**

The contractor shall follow the instructions in CMS Publication 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

Individual physicians and non-physician practitioners who reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice, separate from the reassignment of benefits agreement, he/she may designate their own Par status. Refer to the instructions in Publication 100-04, chapter 1, section 30 for applying the correct Par status to clinic/group practices, organizations and individuals in private practice.

## 15.14.6.2 – PECOS Information

**(Rev. 592, Issued: 05-08-15, Effective: 06-08-15, Implementation: 06-08-15)**

All providers/suppliers must choose to be either Par or Non-Par when enrolling and must maintain the same Par status across all lines of business. The MAC shall search PECOS to determine if an enrollment already exists with the enrolling

provider or supplier's legal business information (i.e.: Legal Business Name, Federal Tax Identification Number).

No Par status change shall be made by the MAC without confirmation from the provider/supplier first. In the event that a provider/supplier submits a Par Agreement and they are currently enrolled as Non-Par, the MAC must confirm with the provider/supplier that the change in the Par status is valid for all lines of business. Likewise, if a provider/supplier does not submit a Par Agreement, and they are enrolled as Par or Non-Par, the MAC shall confirm that the provider or supplier is not changing their current Par status across all lines of business.

## 15.14.7 – Opting-Out of Medicare

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

Normally physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.

However, certain types of physicians and practitioners may "opt-out" of Medicare. A physician or practitioner who opts-out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services. Medicare does not pay anyone for services (except for certain emergency and urgent care services) furnished by an opt-out physician or practitioner. Instead, opt-out physicians and practitioners sign private contracts with beneficiaries. Please refer to Pub. 100-02, Chapter 15, sections 40 – 40.39 for more information regarding maintaining opt-out affidavits and the effects of improper billing of claims during an opt-out period. The instruction included in this chapter is intended for processing opt-out affidavits by the Provider Enrollment staff at the Medicare Administrative Contractors (MACs).

### 15.14.7.1 – Who May Opt-out of Medicare

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

Only certain physicians and non-physician practitioners (referred to as "eligible practitioners" in this section), but not organizations, can "opt-out" of Medicare.

Physicians who are:

- Doctors of medicine or osteopathy,
- Doctors of dental surgery or dental medicine,
- Doctors of podiatry, or
- Doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed.

Non-Physician Practitioners who are

- Physician assistants,
- Nurse practitioners,
- Clinical nurse specialists,
- Certified registered nurse anesthetists,
- Certified nurse midwives,
- Clinical psychologists,
- Clinical social workers, or
- Registered dietitians or nutrition professionals who are legally authorized to practice by the State and otherwise meet Medicare requirements.

This means that neither the eligible practitioner nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the eligible practitioner and the beneficiary that states, in essence, that neither one can receive payment from Medicare for the services that were performed. (The contract, of course, must be signed before the services are provided so the beneficiary is fully aware of the physician's opt-out status.) Moreover, the eligible practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The provider enrollment unit must process these affidavits.

Eligible Practitioners that opt-out of Medicare are not the same as non-participating physicians/suppliers. Non-participating physicians/suppliers are enrolled in Medicare and choose on a claim-by-claim basis whether they want to accept assignment unless the service can only be paid on an assignment related basis as required by the law (e.g., for drugs, ambulance services, etc.). Therefore, non-participating physicians/suppliers must comply with Medicare's mandatory claim submission, assignment, and limiting charge rules. Conversely, opt-out physicians/practitioners are excused from the mandatory claim submission, assignment, and limiting charge rules but **only** when they maintain compliance with all of the requirements for opting out.

In an emergency care or urgent care situation, an eligible practitioner who has opted-out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the eligible practitioner must complete a CMS-855 application.

## 15.14.7.2 – Requirements for an Opt-out Affidavit

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

As stated in Pub. 100-02, Chapter 15, Section 40.9, the affidavit shall state the following, that upon signing the affidavit, the eligible practitioner agrees to the following requirements:

1. Except for emergency or urgent care services, during the opt out period the eligible practitioner will provide services to Medicare beneficiaries only through private contracts, but for their provision under a private contract, would have been Medicare-covered services;

2. The eligible practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt out period, nor will the eligible practitioner permit any entity acting on the eligible practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary;

3. During the opt out period, the eligible practitioner understands that he/she may receive no direct or indirect Medicare payment for services that the eligible practitioner furnishes to Medicare beneficiaries with whom the eligible practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan;

4. An eligible practitioner who opts out of Medicare acknowledges that, during the opt out period, the eligible practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the eligible practitioner's services, directly or on a capitated basis;

5. On acknowledgment by the eligible practitioner to the effect that, during the opt out period, the eligible practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the eligible practitioner has entered into;

6. Acknowledge that the eligible practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the eligible practitioner during the opt out period (except for emergency or urgent care services furnished to the beneficiaries with whom the eligible practitioner has not previously privately contracted) without regard to any payment arrangements the eligible practitioner may make;

7. With respect to an eligible practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;

8. Acknowledge that the eligible practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services;

9. Identify the eligible practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the eligible practitioner during the opt-out period; and

10. Be filed with all MACs who have jurisdiction over claims the eligible practitioner would otherwise file with Medicare, and 42 CFR §405.420 the initial 2-year opt-out period will begin the date the affidavit meeting the requirements of is signed, provided the affidavit is filed within 10 days after the eligible practitioner signs his or her first private contract with a Medicare beneficiary.

MACs shall review initial opt-out affidavits to ensure that they contain the following information in order to create an affidavit record in PECOS:

The eligible practitioner's personal information:

- Full name (first, middle and last),
- Birthdate,
- Address and telephone number,
- License information and
- NPI (if one has been obtained), and
- SSN (if no NPI has been issued).

If MACs need to obtain any data that may be missing in an affidavit, in order to create a PECOS affidavit record, they may obtain that information from other sources (such as the state license board) or they should contact the eligible practitioner only **one time** directly. Contractors shall **not** use Internet-Based PECOS or the CMS 855 form to obtain the information from the eligible practitioner, as the eligible practitioner **is not** enrolling in Medicare. If the eligible practitioner is requested to submit missing information to allow for processing of the affidavit and fails to do so within 30 days, the MAC shall reject the opt-out affidavit.

## 15.14.7.2.1 – Opting-out and Ordering and Referring

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

If an eligible practitioner that wishes to opt-out elects to order and refer items and services, the MACs shall develop for the following information (if not provided on the affidavit):

- An NPI (if one is not contained on the affidavit voluntarily);
- Date of Birth, and;
- SSN (if not contained on the Affidavit).

Note: MACs shall review the List of Excluded Individuals and Entities (LEIE) on the OIG's website and the Excluded Parties List on the GSA's System for Award

Management (SAM) for all eligible practitioners that submit opt-out affidavits. Excluded eligible practitioners may opt-out of Medicare, but cannot order or refer.

If the information listed above is requested but not received, the eligible practitioner's affidavit can be processed, but the eligible practitioner cannot be listed as an ordering and referring provider.

## 15.14.7.2.2 – Acceptable Opt-out Affidavit Formats

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

MACs may provide a sample opt-out affidavit form for eligible practitioners to complete. The opt-out affidavit form must provide spaces for the eligible practitioners to provide their personal information.

Eligible practitioners may also create their own affidavit. If the practitioner elects to do so, he/she should include information found in Section 15.14.7.2.2.1 to ensure timely processing of their opt-out affidavit.

## 15.14.7.2.2.1 – Opt Out Affidavit Sample Form

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

MACs and eligible practitioners may use the information below as their opt-out affidavit form.

I, {Enter Physician/Non-Physician Practitioner Name}, being duly sworn, depose and say:

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt- out period.
- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.
- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under Medicare Advantage.

- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.
- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.
- I have identified myself sufficiently so that the MAC can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.
- I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two-year opt-out period will begin the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Eligible practitioners should also be encouraged to include the following information (to complete an affidavit record in PECOS):

- Eligible Practitioner's NPI
- Eligible Practitioner's Medicare Identification Number (if issued)
- Eligible Practitioner's Social Security Number
- Eligible Practitioner's Date of Birth
- Eligible Practitioner's Specialty
- Eligible Practitioner's E-mail Address
- Eligible Practitioner's request to Order & Refer

## 15.14.7.3 – Requirements of a Private Contract

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

In order to opt-out of Medicare, the eligible practitioner shall complete a "private contract" with their patients that are Medicare beneficiaries. Please refer to Pub. 100-02, Chapter 15, Section 40.8 for private contract definitions and requirements.

## 15.14.7.4 – Determining an Effective Date of an Opt-out Period

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

As noted in Pub. 100-02, Chapter 15, Section 40.17, eligible practitioners receive effective dates based on their participation status.

A. Eligible practitioners that have never enrolled with Medicare

Eligible practitioners are not required to enroll prior to opting-out of Medicare. If a non-enrolled eligible practitioner submits an opt-out affidavit, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

B. Previously Enrolled Non-Participating Practitioners

If a previously enrolled eligible practitioner that is a non-participating physicians/suppliers decides to terminate their active Medicare billing enrollment and instead opt-out of Medicare, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

C. Previously Enrolled Participating Physicians/Suppliers

If a previously enrolled eligible practitioner that is a participating provider (one that accepts assignment for all their Medicare claims) decides to terminate his/her active Medicare billing enrollment and opt-out of Medicare, the effective date of the opt-out period begins the first day of the next calendar quarter. An opt-out affidavit must be received at least 30 days before the first day of the calendar quarter in order to receive January 1, April 1, July 1 or October 1 as their effective date. If the opt-out affidavit is received within 30 days prior to January 1, April 1, July 1 or October 1, the effective date would be the first day of the next calendar quarter. (For example, an enrolled participating eligible practitioner's opt-out affidavit was submitted on December 10th. The eligible practitioner's effective date could not be January 1, as the affidavit was not received 30 days prior to January 1. The effective date would be April 1.) The eligible practitioner would need to remain enrolled as a participating physician/supplier until the end of the next calendar quarter so that claims can be properly submitted until the opt-out period begins.

## 15.14.7.5 – Emergency and Urgent Care Services

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

In the case that an eligible practitioner that has opted-out of Medicare provides emergency or urgent care services, that eligible practitioner must submit an application for enrollment via the Provider Enrollment Chain and Ownership

System (PECOS) or a paper CMS-855I application. Once the eligible practitioner has received his/her Provider Transaction Access Number (PTAN), he/she must submit the claim(s) for any emergency or urgent care service provided. MACs shall contact their Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for additional guidance when this type of situation arises. Please refer to Pub. 100-02, Chapter 15, Section 40.28 for more information on Emergency and Urgent Care Services.

## 15.14.7.6 –Termination of an Opt Out Affidavit

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

As noted in Pub. 100-02, Chapter 15, Section 40.35, an eligible practitioner who has not previously opted-out may terminate their opt-out period early, however notification must be given to the MAC, in writing, signed by the eligible practitioner no later than 90 days after the effective date of the initial 2-year opt-out period. In order to properly terminate an affidavit, the eligible practitioner must:

1. Not have previously opted-out of Medicare (the eligible practitioner cannot terminate a renewal of his/her opt-out);
2. Notify all the MACs that the eligible practitioner has filed an affidavit no later than 90 days after the effective date of the affidavit;
3. Notify all beneficiaries (or their legal representation), that the eligible practitioner entered into private contracts with, of the eligible practitioner's decision to terminate their opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period and;
4. Refund to each beneficiary all payments collected in excess of the Medicare limiting charge or deductibles and coinsurance.

For eligible practitioners that were previously enrolled to bill Medicare for services, the MAC shall reactivate the eligible practitioner's enrollment record in PECOS and reinstate his/her PTAN as if no opt-out affidavit existed. The physician or NPP may bill for services provided during the opt-out period.

For eligible practitioners that were not previously enrolled to bill Medicare for services, the MAC shall remove the affidavit record from PECOS so that the eligible practitioner can submit the appropriate application(s) (via PECOS or paper CMS-855 for individual and/or reassignment enrollment) in order to establish an enrollment record in PECOS, so the physician or NPP may bill for services rendered during the opt-out period.

## 15.14.7.7 – Opt-out Period Auto-Renewal and Cancellation of the Opt-out Affidavit

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

Eligible practitioners that initially opted-out or renewed an affidavit on or after June 16, 2015 need not submit a renewal of their affidavit. The opt-out will be automatically renewed for another 2 year period. However, if the eligible practitioner decides to cancel his/her opt-out, he/she must submit a written, signed notice to each MAC to which he or she would file claims absent the opt-out, not later than 30 days before the end of the current 2-year opt-out period.

If the eligible practitioner decides to enroll in Medicare after his or her opt-out is canceled, he or she must submit an application via PECOS or a paper CMS-855I application. The effective date of enrollment cannot be before the cancellation date of the opt-out period. (For example, an eligible practitioner submits a cancellation of his or her opt-out to end the period on March 31, which is two years from the eligible practitioner's opt-out affidavit effective date. His/her requested Medicare effective date of enrollment cannot be before April 1.)

## 15.14.7.7.1 – Opt-out Period Auto-Renewal Report and Opt-Out Renewal Alert

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

The MACs shall issue an Opt-Out Renewal Alert Letter (found in Section 15.24.16.6 of this chapter) to any eligible practitioners whose opt-out period is set to auto-renew.

To accomplish this, CMS will provide a monthly opt-out report to all contractors via the Share Point Ensemble site. The MACs shall access the report monthly through the Share Point Ensemble site. The MACs shall review the opt-out report for opted-out eligible practitioners that will auto-renew in the next 3 and a half months. MACs shall issue an Auto-Renewal Alert Letter to eligible practitioners at least 90 days prior to the auto-renewal date, so the eligible practitioner has at least 60 days prior to the date a cancellation notice must be submitted to cancel the current opt-out.

The Opt-out Auto-Renewal Alert Letter will provide the date the current opt-out period will be auto renewed and the date that the eligible practitioner will need to submit a cancellation request. The letter will provide the eligible practitioner appeal rights if he/she fails to submit a cancellation request and the opt-out renews.

The MACs shall complete the Opt-Out Renewal Alert Letter Report to include the date the Alert Letter was issued and post their reports no later than the 15$^{th}$ of the following month to the Share Point Ensemble site and email their PEOG BFL when the report has been posted.

If an eligible practitioner submits a CMS-855I and/or a CMS-855R (paper or web application) without submitting a cancellation request of his or her opt-out, the MACs shall issue a development for the cancellation notice. Once the cancellation notice is received, the MACs shall then process the application(s).

If the eligible practitioner submits a cancellation request (after development, as noted above, or without a prior application submission) at least 30 days before the end of the current opt-out period or after the opt-out period automatically renews, MACs shall contact their Provider Enrollment & Operations Group (PEOG) Business Function Lead (BFL) for guidance regarding the opt-out cancellation. This guidance will be issued on a case-by-case

## 15.14.7.8 – Opting-out vs. Enrolling for the Sole Purpose of Ordering and Referring and/or Prescribing

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

Physicians and certain non-physician practitioners (NPPs) who wish to enroll for the sole purpose of ordering and referring submit an application via PECOS or via the paper form CMS-855O application. These physicians and NPPs do not receive payments from Medicare, as they do not submit claims as performing providers.

An eligible practitioner that has opted out of Medicare does not need to additionally submit an application to enroll as an ordering and referring provider, if they indicate that they wish to order and refer (providing the necessary information on their affidavit as noted in Section 15.14.7.2).

## 15.14.7.9 – Failure to Properly Cancel or Terminate Opt-out

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

Eligible practitioners that fail to properly cancel or terminate their opt-out shall be provided an opportunity to appeal the decision to continue the auto-renewal of the opt-out or continuation of the eligible practitioner's initial opt-out period.

The Opt-Out Approval letters include appeal rights for eligible practitioners that initially opt-out and fail to properly terminate the opt-out within 90 days of the approval.

## 15.14.8 – Assignment of Part B Provider Transaction Access Numbers (PTANs)

**(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)**

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assign additional PTAN(s) to a supplier merely because the individual or entity requests one - the only exception being for hospitals that request separate billing numbers for their hospital departments in section 2C of the Form CMS-855B. However, a hospital requesting an additional PTAN must associate the new PTAN with a National Provider Identifier in section 4 of the Form CMS-855.

## 15.16 – Ordering/Certifying Suppliers Who Do Not Have Medicare Billing Privileges

**(Rev. 435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)**

## 15.16.1 – Ordering/Certifying Suppliers – Background

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

### A. Who Can Order/Certify

Generally, depending upon state law, the following physicians and non-physician practitioners are permitted to order or certify items or services for Medicare beneficiaries:

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry
- Doctors of optometry
- Physician assistants
- Certified clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Certified nurse midwives
- Clinical social workers

Most physicians and non-physician practitioners enroll in Medicare so they can receive reimbursement for covered services to Medicare beneficiaries. However, some physicians and non-physician practitioners who are not enrolled in Medicare via the Form CMS-855I may wish to order or certify items or services for Medicare beneficiaries. These individuals can become eligible to do so by completing the Form CMS-855O via paper or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) process.

**NOTE:** It is important to observe that physicians and non-physician practitioners that complete the Form CMS-855O do not and will not send claims to a Medicare contractor for services they furnish. They are not afforded Medicare billing privileges for the purpose of submitting claims to Medicare directly for services that they furnish to beneficiaries. Such persons may be:

- Employed by the Department of Veterans Affairs (DVA)
- Employed by the Public Health Service (PHS)
- Employed by the Department of Defense (DOD) Tricare
- Employed by the Indian Health Service (IHS) or a tribal organization

- Employed by a federally qualified health center (FQHC), rural health clinic (RHC), or critical access hospital (CAH)
- Licensed residents and physicians in a fellowship (see subsection B)
- Dentists, including oral surgeons
- Pediatricians

**B. CMS Final Rule 6010-F**

CMS-6010-F was published in the Federal Register on April 27, 2012. It set forth and/or reiterated several policies including, but not limited to, the following:

1. Residents (as defined in 42 CFR § 413.75 and which includes interns and fellows) who are enrolled in an accredited graduate medical education program in a state that licenses or otherwise enables such individual to practice or order these items or services may enroll in Medicare to order and certify.

2. To order and certify for Medicare items and services, a provider or supplier must be enrolled in either PECOS or the Medicare contractor's legacy system.

3. The ordering/certifying provisions of the final rule only apply to items of durable medical equipment, prosthetics, orthotics and supplies, imaging and clinical laboratory services, and home health services.

An interim final rule – CMS-6010-IFC, which was published in the Federal Register on May 5, 2010 – used the terms "refer" and "referring," rather than "certify" and "certifying." The April 27, 2012 final rule stated that the latter two terms should be used instead of "refer" and "referring."

## 15.16.2 – Processing Initial Form CMS-855O Submissions

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

The instructions in sections 15.7 through 7.1.6.2 of this chapter take precedence over those in sections 15.16.2 and 15.16.3.

**A. Receipt**

Upon receipt of an initial Form CMS-855O (or - for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) submissions - a certification statement), the contractor shall create a logging & tracking (L & T) record.

**NOTE:** The physician/non-physician practitioner need not submit a Form CMS-460, a Form CMS-588, or an application fee with his or her Form CMS-855O.

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the form in accordance with the

instructions outlined in that section.

**B. Verification**

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify all of the information on the Form CMS-855O. This includes, but is not limited to:

- Verification of the individual's name, date of birth, social security number, and National Provider Identifier (NPI).

- Verification that the individual meets the requirements for his/her supplier type. (The contractor reserves the right to request that the individual submit documentation verifying his or her professional licensure, credentials, or education.)

- Verification that the individual is of a supplier type that can legally order or certify.

- Reviewing the Medicare Exclusion Database (MED) and System for Award Management (SAM) to ensure that the individual is not excluded or debarred.

If, at any time during the verification process, the contractor needs additional or clarifying information from the physician/non-physician practitioner, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

**C. Disposition**

Upon completion of its review of the form, the contractor shall approve, deny, or reject it.

Grounds for denial are as follows:

- The supplier is not of a type that is eligible to use the Form CMS-855O.

- The supplier is not of a type that is eligible to order or certify items or services for Medicare beneficiaries.

- The supplier does not meet the licensure, certification or educational requirements for his or her supplier type.

- The supplier is excluded per the MED and/or debarred per the SAM.

If the contractor believes that another ground for denial exists for a particular submission, it should contact its CMS Provider Enrollment Business Function Lead for guidance.

The Form CMS-855O may be rejected if the supplier fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the Form CMS-855O submission, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter to the supplier notifying him or her of the denial or rejection and the reason(s) for it. The letter shall follow the formats outlined in sections 15.24.22 (rejections) and 15.24.23 (denials) of this chapter. Denial letters shall be sent via certified mail. Rejection letters shall be sent by mail or e-mail. (**NOTE:** A denial triggers appeal rights. A rejection does not.)

If the Form CMS-855O is approved, the contractor shall: (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval. The letter shall follow the format outlined in section 15.24.21 of this chapter.

**E. Miscellaneous**

**NOTE:** The contractor shall observe the following:

1. The supplier shall be treated as a non-participating supplier (or "non-par").

2. If the supplier is employed by the DVA, the DOD, or the IHS, he or she – for purposes of the Form CMS-855O - need only be licensed or certified in one State. Said State need not be the one in which the DVA or DOD office is located.

3. Nothing in sections 15.16.2 through 15.16.4 affects any existing CMS instructions regarding the processing of opt-out affidavits.

4. Suppliers cannot submit an abbreviated version of the Form CMS-855I in lieu of the Form CMS-855O.

5. The effective date of enrollment shall be the date on which the contractor received the paper form or Web-based certification statement in its mailroom.

6. If the supplier's Form CMS-855O has been approved and he or she later wants to obtain Medicare billing privileges, he or she must voluntarily withdraw his or her Form CMS-855O enrollment prior to receiving Medicare billing privileges. (The supplier, of course, must complete the Form CMS-855I in order to receive

Medicare billing privileges.)

## 15.16.3 – Processing Form CMS-855O Change of Information Requests

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

### A. Receipt

Upon receipt of a Form CMS-855O change of information request (or - for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) change requests - a certification statement), the contractor shall create a logging and tracking (L & T) record.

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it may return the change request via the instructions outlined in that section.

Suppliers who are enrolled in Medicare via the Form CMS-855I may not report changes to their enrollment information via the Form CMS-855O. They must use the Form CMS-855I. Similarly, suppliers whose Form CMS-855O submissions have been approved must use the Form CMS-855O to report information changes; they cannot use the Form CMS-855I for this purpose.

### B. Verification

Unless stated otherwise in this chapter or in another CMS directive, the contractor shall verify the new information that the supplier furnished on the Form CMS-855O. (This includes checking the supplier against the Medicare Exclusion Database and the System for Award Management (SAM).) If, at any time during the verification process, the contractor needs additional or clarifying information, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30 calendar days of the contractor's request.

### C. Disposition

Upon completion of its review of the change request, the contractor shall approve, deny, or reject the submission. The principal ground for denial will be that the new information was furnished, but could not be verified. If the contractor believes that another ground for denial exists with respect to a particular submission, it should contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

The change request may be rejected if the supplier failed to furnish all required information on the form within 30 calendar days of the contractor's request to do

so. The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the change request, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the denial or rejection and the reason(s) for it.

If the change request is approved, the contractor shall (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval.

## 15.16.4 – Form CMS-855O Revocations

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

If the contractor determines that grounds exist for revoking the supplier's Form CMS-855O enrollment, it shall:

- Switch the supplier's Provider Enrollment, Chain and Ownership System (PECOS) record to a " revoked" status,
- End-date the PECOS record, and
- Send a letter via certified mail to the supplier stating that his or her Form CMS-855O enrollment has been revoked. The letter shall follow the format outlined in section 15.24.24 of this chapter.

Grounds for revoking the supplier's Form CMS-855O enrollment are as follows:

- The supplier is no longer of a type that is eligible to order or certify.
- The supplier no longer meets the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the Medicare Exclusion Database (MED) and/or debarred per the System for Award Management (SAM).

For purposes of the Form CMS-855O only, the term "revocation" effectively means that:

- The supplier may no longer order or certify Medicare services based on his or her having completed the Form CMS-855O process.
- If the supplier wishes to submit another Form CMS-855O, he or she must do so as an initial applicant.

There are appeal rights associated with the revocation of a supplier's Form CMS-

855O enrollment.

## 15.16.5 – Conversion from Form CMS-855O to Form CMS-855I – PECOS Requirements

**(Rev. 474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)**

Internet-based PECOS permits an individual provider to convert his or her current Form CMS-855O application to a Form CMS-855I enrollment and vice versa. Such providers shall follow the current process for creating a new application. When PECOS detects existing approved enrollments, the provider will be prompted to select from a list of those enrollments that will be used to pre-populate the information for the new application. The provider must confirm that he or she wants to withdraw the existing enrollments before the new application may be submitted.

The enrollments to be withdrawn are displayed in a new section of the ADR in PECOS Administrative Interface (AI). The contractor shall review this information and take the appropriate action to voluntarily withdraw the enrollments listed. The contractor shall begin working the Form CMS-855I enrollment but leave it in "In Review" status while withdrawing the other enrollments. A logging and tracking (L&T) submittal reason of Voluntary Termination shall be used to withdraw the Form CMS-855O enrollment. The effective date of the withdrawn enrollments shall be one day prior to the effective date of the Form CMS-855I enrollment. If it is determined that the Form CMS-855O enrollment requiring withdrawal is outside of the contractor's jurisdiction, the contractor shall notify the other contractor via email using the "Associate Profile Contact List," stating that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and include the email in its files as documentation.

If the provider submits a paper Form CMS-855I application and it is determined that a current Form CMS-855O enrollment exists within the contractor jurisdiction, the contractor shall voluntarily withdraw the Form CMS-855O enrollment. If it is determined that the current Form CMS-855O enrollment is outside of the contractor's jurisdiction, the contractor shall notify the other contractor via email using the "Associate Profile Contact List" that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and include the email in its files as documentation.

If the provider submits a paper Form CMS-855O to voluntarily withdraw his or her enrollment as well as a paper Form CMS-855I to begin billing Medicare, the contractor shall not contact the provider to confirm the submissions unless the contractor has reason to believe that what was submitted was not the provider's intention. If it is determined that the provider submitted applications to convert his or her existing Form CMS-855O enrollment into a Form CMS-855I enrollment in error (either via paper or Internet-based PECOS), the contractor shall reject the application, thus returning the enrollment record back to its previous state.

## 15.16.6 – Form CMS-855O Processing Guide

**(Rev. 773, Issued: 02-23-18, Effective: 03-23-18, Implementation: 03-23-18)**

Go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending to view the CMS-855O Processing Guide, which constitutes a general Form CMS-855O processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855O, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855O applications.

## 15.17 – Establishing an Effective Date of Medicare Billing Privileges

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

(This section applies to the following individuals and organizations: physicians; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, physical therapists, occupational therapists; physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above; and ambulance suppliers.)

### A. Background

In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above is the later of:

- The date the supplier filed an enrollment application that was subsequently approved, or
- The date the supplier first began furnishing services at a new practice location.

**NOTE**: The date of filing for Form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.

### B. Retrospective Billing

Consistent with 42 CFR §424.521(a), the individuals and organizations identified above may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements, <u>and</u>

- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements including state licensure) during the 30-day period before an application was submitted and no final adverse action, as identified in § 424.502, precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for a determination on this issue.

**C. Legal Distinction between Effective Date of Enrollment and Retrospective Billing Date**

The effective date of enrollment is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non- Medicare enrolled physician begins furnishing services at an office on March 1. She submits a paper Form CMS-855I initial enrollment application on May 1; the contractor receives the application on May 4. The application is approved on June 1. The physician's effective date of enrollment is May 4, which is the later of (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 4 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR § 424.521(a) are met.

Hence, the effective date entered into PECOS and the Multi-Carrier System will be April 4; claims submitted for services provided before April 4 will not be paid.

## 15.17.1 - Effective Date for Certified Providers and Certified Suppliers

**(Rev. 404, Issued: 01-20-12, Effective: 04-22-12, Implementation: 04-22-12)**

The final Fiscal Year (FY) 2011 Hospital Inpatient Prospective Payment System (IPPS) final rule was published on August 16, 2010 (75 FR 50042) and became effective October 1, 2010. Several provisions in the rule directly affect areas of survey and certification responsibility.

Section 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 was revised to clarify that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met. Such requirements include the Medicare contractor's review and verification of the provider/supplier's Form CMS-855 application.

These clarifications were necessary because of a September 28, 2009 decision of the Appellate Division of the Department Appeals Board (DAB). The DAB's interpretation of §489.13 was that it did not include enrollment application processing as among the Federal requirements that must be met. In that case, a State Agency (SA) had conducted a survey of an applicant on July 6, 2007, prior to receiving the November 21, 2007 notice from the Medicare contractor that was recommending approval of the applicant's enrollment application. The CMS Regional Office (RO) issued a provider approval effective November 21, 2007, consistent with our traditional interpretation of §489.13. The DAB, however, ruled that the effective date must be July 6, 2007. The DAB agreed with the applicant that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the provider to meet [under §489.13], but rather a requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

Although SAs and accreditation organizations (AOs) are aware that - in accordance with Section 2003B of the State Operations Manual (SOM) - they should not perform a survey of a new facility until the Medicare contractor has made a recommendation for approval, circumstances do occur where the sequence is reversed. AOs, in particular, often find it challenging to confirm whether the Medicare contractor has made its recommendation. This is because AOs are dependent upon the applicant providing copies of the pertinent notices. When the survey occurs prior to the enrollment verification activities, we believe it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date on which the contractor determined that the enrollment application verification.

Accordingly, §489.13(b) now states that:

"Federal requirements include, but are not limited to –

(1) Enrollment requirements established in part 424, Subpart P, of this chapter.

CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

(2) The requirements identified in §§489.10 and 489.12; and

(4) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification."

## 15.17.2 - Effective Date for MDPP Suppliers

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

In accordance with 42 CFR §424.205(f), the effective date for billing privileges for MDPP suppliers is the later of:

- The date the supplier filed an enrollment application that was subsequently approved,
- The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
- The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.

Under no circumstances should an effective date for billing privileges be prior to April 1, 2018. For any Form CMS-20134 that were submitted prior to April 1, 2018 and subsequently approved, the contractor shall note April 1, 2018 as the MDPP supplier's effective date, even if this date is in the future.

**NOTE**: The date of filing for paper Form CMS-20134 applications is the date on which the contractor received the application. For Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, the date of filing is the date that the contractor received an electronic version of the enrollment application <u>and</u> a signed certification statement submitted via paper or electronically.

## 15.18 – Ordering and Certifying Documentation - Maintenance Requirements

**(Rev. 587, Issued: 04-17-15, Effective: 07-20-15, Implementation: 07-20-15)**

A. Background

Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation (see next paragraph) for 7 years from the date of service, and

- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

In addition, under §424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke enrollment under §424.535(a)(10).

B. Justification for Request for Documentation

Absent a CMS directive to the contrary, the contractor shall request the documentation described in subsection (A) if it has reason to believe that the provider, supplier, physician or eligible professional (hereinafter collectively referred to as “provider”) is not maintaining the documentation in accordance with §424.516(f)(1) or (2). Examples of when a request might be appropriate include, but are not limited to:

- The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has generated an alert with respect to the provider.

- The provider has been the subject of a recent Zone Program Integrity Contractor referral.

- The provider maintains an elevated surety bond amount.

These are, of course, only examples of when a request could perhaps be warranted. Ultimately, the contractor would have to consider the surrounding circumstances of

each case, including those involving situations not addressed in the aforementioned examples. The contractor may always contact its CMS Provider Enrollment Business Function Lead (PEBFL) if it is uncertain as to whether a particular documentation request should be made.

**NOTE:** Documentation cannot be requested for written orders and certifications dated prior to July 6, 2010.

C. Maintaining and Providing Access to Documentation

Under §424.516(f), CMS or a Medicare contractor may request access to documentation described in §424.516(f). The term "access to documentation" means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor. All providers and suppliers who either furnish, order, or certify the items described in section A above are subject to this requirement and are individually responsible for maintaining these records and providing them upon request.

For example, if a Medicare contractor requests copies of all orders for wheelchairs from an ordering physician for all beneficiaries with dates of service from November 1, 2014 through November 10, 2014, the ordering physician must provide the copies, in full, according to the specific request. If copies cannot be provided because the physician or eligible professional did not personally maintain the records or can only be partially provided, then the requirement to maintain this documentation and provide access to it will not have been met and the provider, supplier, physician, or eligible professional may be subject to the revocation basis set forth in §424.535(a)(10).

Examples of Sufficient and Deficient Access may include, but are not limited to:

| Sufficient Access | Deficient Access |
|---|---|
| • All documentation requested | • Providing none of the requested documentation |
| • Documentation specific to the order(s) or certification(s), as requested | • Providing only a portion of the requested documentation |
| • Documentation for the dates of service or billing periods requested | • Providing similar documentation that does not contain the order or certification requested |
| | • Providing other documents NOT requested by CMS or a Medicare contractor and/or not specifically directing attention to the requested documentation |

CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf. However, it remains the responsibility of the individual or entity upon whom/which the request has been made to provide documentation. All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with not complying with the documentation request.

D. Process

If the contractor believes that a request for documentation is warranted, it shall prepare and send a request letter to the provider via mail. If the provider:

- Fails to respond within 30 calendar days of the contractor's request (i.e., a complete non-response), the contractor shall revoke enrollment using §424.535(a)(10) as the basis. Prior approval from the contractor's PEOG BFL is not necessary. A 1-year re-enrollment bar shall be imposed.

- Timely furnishes documentation that the contractor nevertheless deems inadequate, the contractor shall send a developmental letter via mail, e-mail or fax to the provider that requests more sufficient documentation. If the provider fails to submit such documentation (either via a complete non-response or by submitting additional inadequate documentation), the contractor shall refer the matter (including the documentation submitted to date) to its CMS PEBFL. CMS will determine whether a revocation is warranted and will notify the contractor via e-mail of its decision.

- Furnishes documentation that the contractor deems adequate, the contractor need not take further action other than to place the documentation and the documentation request letter(s) in the provider file.

E. Additional Guidance

The contractor shall also abide by the following:

1. When preparing the letter referred to in (C)(1) above, the contractor shall use the appropriate model language in (E) or (F) below. Note, however, that while the letters request copies of orders, the contractor has the discretion to ask for different or additional documentation (e.g., documentation that supports the legitimacy of a particular service or the payment of a particular claim). Copies of orders need not be requested in every situation. As alluded to in (B) above, the contractor would have to examine the facts of each case in determining the type(s) of documentation to be requested.

2. There may be situations in which CMS directs the contractor to request documentation in a particular case. The contractor shall follow the instructions in

this section 15.18 with respect to doing so.

3. The contractor shall contact its CMS PEBFL if it has questions as to whether particular submitted documentation is adequate or legitimate – specifically, whether it falls within the category of documentation described in section (A) above.

F. Model Language for § 424.516(f)(1) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in §424.516(f)(1).

"Dear Provider/Supplier:

Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service, and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(1), please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries' names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the provider or supplier furnished the items/services in question. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10)."

G. Model Language for §424.516(f)(2) Situations

The contractor shall use the model language below if it is requesting documentation from a provider or supplier furnishing the items or services addressed in § 424.516(f)(2).

"Dear Physician/Professional:

Under 42 CFR §424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

Consistent with §424.516(f)(2), please mail to us copies of the orders for items or services that you issued for the following beneficiaries on the dates specified:

(Contractors shall insert the beneficiaries' names (up to 5 may be listed, unless CMS specifies otherwise), appropriate identification information, and the dates on which the orders were made. The contractor has the discretion to determine the cases/services that are included in this documentation request as well as the type(s) of documentation to be requested.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

(Cite appropriate address)

Failure to timely submit this documentation may result in the revocation of your enrollment pursuant to 42 CFR §424.535(a)(10)." (For individuals enrolled via the Form CMS-855O, the contractor shall instead use the following language: "Failure to timely submit this documentation may result in the revocation of your Form CMS-855O enrollment.")

## 15.19 – Application Fees and Additional Screening Requirements

**(Rev 371, Issued: 03-23-11, Effective: 03-25-11, Implementation: 03-25-11)**

## 15.19.1 – Application Fees

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

## A. Background

Pursuant to 42 CFR §424.514 - and with the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR §424.515 (regardless of whether the revalidation application was requested by CMS or voluntarily submitted by the provider or supplier), must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that the contractor receives on or after March 25, 2011.

For purposes of this requirement, the term "institutional provider," as defined in 42 CFR §424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (not including physician and non-physician practitioner organizations), Form CMS-20134, Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

## B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011 through December 31, 2011 was $505.00. The fee for January 1, 2016 through December 31, 2016 is $554.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

Per 42 CFR §424.514(d)(2)(v), the application fee is non-refundable, except if it was submitted with one of the following:

a. A hardship exception request that is subsequently approved;

b. An application that was rejected prior to the contractor's initiation of the screening process, or

c. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR§424.570.

(For purposes of (B)(2)(b) above, the term "rejected" includes applications that are returned pursuant to section 15.8.1 of this chapter.)

In addition, the fee should be refunded if:

- It was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number).

- It was not part of an application submission.

3. Format

The provider or supplier must submit the application fee electronically through https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do, either via credit card, debit card, or check.

Also, with respect to the application fee requirement:

- The fee is based on the Form CMS-855 or Form CMS-20134 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

- A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS- 855B is exempt from the fee even if it is: (1) tribally-owned/operated or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS- 855A enrollment, a fee is required because the hospital is adding a practice location.

**C. Hardship Exception**

1. Background

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 or Form CMS-20134 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters shall not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider, and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

The application fee generally should not represent a significant burden for an adequately capitalized provider or supplier. Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

(a) Considerable bad debt expenses,

(b) Significant amount of charity care/financial assistance furnished to patients,

(c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

(d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

(e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL). CMS will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 19.1(D) below. If the provider fails to submit appropriate documentation to support its request, the contractor is not required to contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG BFL. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

**D. Receipt**

If an application fee is required the contractor shall undertake the following:

a. Determine whether the provider has-- (1) Paid the application fee via Pay.gov; and/or (2) Included a hardship exception request with the application or certification statement.

b. If the provider--

i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.

iii. Has submitted a hardship exception request but has not paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e- mail to its PEOG BFL. If CMS:

a. Denies the hardship exception request, it will notify the provider in the decision letter (on which the contractor will be copied) that the

application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall determine whether the fee has been submitted via Pay.gov.

b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied); or

iv. Has submitted a hardship exception request and has paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e- mail to its PEOG BFL. As the fee has been paid, the contractor shall begin processing the application as normal.

**E. Year-to-Year Transition**

There may be isolated instances where, at the end of a calendar year, an institutional provider pays the fee amount for that year (Year 1), yet the submission date (for Internet-based PECOS applications) or the application postmark date (for paper applications) falls in the beginning of the following year (Year 2). Assuming that Year 2's fee is higher than Year 1's, the provider will be required to pay the Year 2 fee. The contractor shall not begin processing the application until the entire fee amount has been paid. Accordingly, the contractor shall (1) send an e-mail to its PEOG BFL requesting a full refund of the fee and including any pertinent documentation in support of the request, and (2) send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the correct fee amount (i.e., the Year 2 amount) via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

**F. Appeals of Hardship Determinations**

A provider may appeal CMS' denial of its hardship exception request via the procedures outlined below:

1. If the provider is dissatisfied with CMS' decision to deny a hardship exception request, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination (e.g., CMS' denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

Centers for Medicare & Medicaid
Services Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop: AR-18-50
Baltimore, MD 21244-
1850

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post- hardship exception request instructions in subsections (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

CMS has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be:

(a) Conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request.

(b) Based on CMS' review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, CMS will send a letter to the provider or supplier to acknowledge receipt of its request. In its acknowledgment letter, CMS will advise the requesting party that the reconsideration will be conducted and a determination issued within 60 days from the date of the request.

If CMS denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If CMS approves the reconsideration request, it will notify the provider of this via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable. If the application has already been rejected, request that the provider resubmit the application without the fee.

Corrective Action Plans (CAPs) may not be submitted in lieu of or in addition to a request for reconsideration of a hardship exception request denial.

2. If the provider is dissatisfied with the reconsideration determination regarding the application fee, it may request a hearing before an Administrative Law Judge (ALJ). Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

Department of Health and Human Services Departmental

Appeals Board (DAB)
Civil Remedies Division,
Mail Stop 6132 330
Independence Avenue,
S.W.
Cohen Bldg., Room G-644 Washington,
D.C. 20201
ATTN: CMS Enrollment Appeal

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request, and the application has already been rejected, the contractor –once PEOG informs it of the ALJ's decision - shall notify the provider via letter, e- mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

If the DAB reverses the ALJ's decision and approves the hardship exception request, and the application has already been rejected, the contractor - once PEOG informs it of the DAB's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee.

To the extent permitted by law, a provider or supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such request shall be filed within 60 days from receipt of the notice of the DAB's decision.

**G. Miscellaneous**

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument It shall instead

treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non- physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application. For MDPP suppliers, which have administrative locations and not practice locations, the application fee must only be paid upon initial enrollment and revalidation, and not when an additional administrative location is being added to an initial application.

3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:

- Reporting a change of ownership via the Form CMS-855B, Form CMS- 855S, or Form CMS-20134. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

- Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS).

- Requesting a reactivation of the provider's Medicare billing privileges unless the provider had been deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.

- Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed below. Physicians, non-physician practitioners, physician groups and non- physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per section 15.19.2.5 of this chapter. Similarly, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

4. Non-Payment of the Fee - If the application is rejected or denied due to non- payment of the fee, the contractor shall:

- Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.
- Indicate in PECOS that a developmental request was made.
- Switch the enrollment record to a "denied" or "rejected" status (as applicable) per section 15.19.1(D).
- Notify the applicant of the rejection or denial in accordance with section 15.19.1(D).

5. Refund Requests – Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For credit card refunds, the provider shall include its Pay.gov receipt or the Pay.gov tracking ID number; if the fee was paid via ACH Debit, a W-9 is required.

## 15.19.2 – Screening Categories

**(Rev. 371, Issued: 03-23-11, Effective: 03-25-11, Implementation: 03-25-11)**

## 15.19.2.1 – Background

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

Consistent with 42 CFR § 424.518, newly-enrolling and existing providers and suppliers will, beginning on March 25, 2011, be placed into one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

**A. Limited**

The “limited” level of categorical screening consists of the following provider and supplier types:

- Physicians
- Non-physician practitioners other than physical therapists
- Physician group practices
- Non-physician group practices other than physical therapist group practices
- Ambulatory surgical centers
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease facilities
- Federally qualified health centers
- Histocompatibility laboratories
- Hospitals (including critical access hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities.
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Outpatient physical therapy/outpatient speech pathology providers enrolling via the Form CMS-855A
- Pharmacies that are newly enrolling or revalidating via the Form CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics
- Skilled nursing facilities

For providers and suppliers in the “limited” category, the contractor shall (unless section 15.19.2.5 of this chapter applies) process initial, revalidation, and new location applications in accordance with existing instructions.

**B. Moderate**

The “moderate” level of categorical screening consists of the following provider and supplier types:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRSs)
- Revalidating home health agencies (HHAs)
- Revalidating DMEPOS suppliers
- Revalidating MDPP suppliers

For providers and suppliers in the “moderate” level of categorical screening, the contractor shall (unless section 15.19.2.2 of this chapter or another CMS directive applies):

1. Process initial, revalidation, and new location applications in accordance with existing instructions; and

2. Except for revalidating DMEPOS suppliers, order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) in accordance with sections 2(a) through (e) below. The site visit, which the National Site Visit Contractor (NVSC) will perform, is to ensure that the supplier is in compliance with CMS’s enrollment requirements. Unless stated otherwise in this chapter, the scope of the site visit will be consistent with section 15.19.2.2.

    a. <u>Ambulance suppliers, independent clinical laboratories, physical therapists, and physical therapist groups</u>

        - <u>Initial application</u> – If the supplier submits an initial application, the contractor shall order a site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

        - <u>Revalidation</u> – If the supplier submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

        - <u>New location</u> - The contractor shall order a site visit of the location. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

b. CMHCs

- Initial application - In addition to the site visit discussed in section 15.4.1.1(B)(1) of this chapter, the contractor shall order a site visit after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the CMHC. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

- Revalidation - If the CMHC submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

- New location - The contractor shall order a site visit of the location after the contractor receives notice of approval from the RO but before the contractor switches the provider's enrollment record to "Approved." The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. CORFs, hospices and PXRSs

- Initial application – If the provider/supplier submits an initial application, the contractor shall order a site visit after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the provider/supplier. The contractor shall not convey Medicare billing privileges to the provider/supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.

- Revalidation – If the provider/supplier submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

- New location - The contractor shall order a site visit of the location after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to "Approved." The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

d. IDTFs

- Initial applications – The NSVC will conduct site visits of initially enrolling IDTFs consistent with section 15.4.19.6 of this chapter.

- Revalidations - The NVSC will conduct site visits of revalidating IDTFs (prior to the contractor's final decision regarding the revalidation application) consistent with section 15.4.19.6 of this chapter.

- Code Changes – The NSVC will conduct site visits for IDTF code changes as specified in section 15.4.19.6(B) of this chapter.

e. Revalidating HHAs – If an HHA submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

f. Revalidating DMEPOS suppliers – The National Supplier Clearinghouse (NSC) shall conduct a site visit of the DMEPOS supplier prior to making a final decision regarding the revalidation application.

g. Revalidating MDPP Suppliers – If an MDPP supplier submits a revalidation application, the contractor shall order a site visit. The Contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

**C. High**

The "high" level of categorical screening consists of the following provider and supplier types:

- Newly enrolling DMEPOS suppliers
- Newly enrolling HHAs (including HHAs that must submit an initial enrollment application pursuant to § 424.550(b)(1))
- Newly enrolling MDPP suppliers

For providers and suppliers in the "high" level of categorical screening:

1. The contractor shall process the application in accordance with existing instructions; and

2. The NSVC will perform a site visit for newly enrolling HHAs and MDPP suppliers. (The NSC will perform a site visit for newly enrolling DMEPOS suppliers.) For initially enrolling HHAs, the contractor shall order a site visit via PECOS after the contractor receives the tie-in notice or approval letter from the RO but before the contractor switches the provider's

enrollment record to “Approved.” The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

**NOTE:**

- Enrolled DMEPOS suppliers that are adding another location will be classified as “high” for screening purposes. (See section 15.19.2.3 below for information regarding DMEPOS changes of ownership and tax identification number (TIN) changes.)

- Newly-enrolling HHA sub-units fall within the “high” level of categorical screening.

- The addition of a new HHA branch falls within the “moderate” level of categorical screening. The contractor shall order a site visit of the location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” This is to ensure that the provider is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

This is the only site visit of the new HHA branch that must be performed prior to the record being switched to “Approved.”

- The addition of a new MDPP supplier administrative location that does not result in a new PTAN does not require an additional site visit. Any additional MDPP supplier administrative location that results in a new PTAN, either due to being in a new jurisdiction or because of a new CDC organizational code, the contractors shall order a site visit of the location through PECOS. This is to ensure that the provider is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

branch that must be performed prior to the record being switched to “Approved.”

## 15.19.2.2 - Scope of Site Visit

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

### A. DMEPOS Suppliers and IDTFs

The scope of site visits of DMEPOS suppliers and IDTFs shall continue to be conducted in accordance with existing CMS instructions and guidance.

### B. Other Provider and Supplier Types

For all provider and supplier types – other than DMEPOS suppliers and IDTFs – that are subject to a site visit in accordance with this section, the SVC will perform such visits consistent with the procedures outlined in sections 20 and 20.1 of this chapter. This includes the following:

- Documenting the date and time of the visit, and including the name of the individual attempting the visit;
- Photographing the provider or supplier's business for inclusion in the provider/supplier's file. All photographs will be date/time stamped;
- Fully documenting observations made at the facility, which could include facts such as: (a) the facility was vacant and free of all furniture; (b) a notice of eviction or similar documentation is posted at the facility, and (c) the space is now occupied by another company;
- Writing a report of the findings regarding each site verification; and
- Including a signed declaration stating the facts and verifying the completion of the site verification. (The sample declaration identified in section 20.1 of this chapter is recommended.)

In terms of the extent of the visit, the SVC will determine whether the following criteria are met:

- The facility is open
- Personnel are at the facility
- Customers are at the facility (if applicable to that provider or supplier type)
- The facility appears to be operational

For MDPP suppliers, the contractor shall check the above criteria as well as:

- Ensure that the facility is not a private residence
- Ensure that signage exists denoting the facility's legal business or DBA name

This will require the site visitor(s) to enter the provider or supplier's practice location/site, rather than simply conducting an external review.

If any of the 4 elements listed above are not met, the enrollment contractor will, as applicable - and using the procedures outlined in this chapter and in existing CMS instructions - deny the provider's enrollment application pursuant to §424.530(a)(5)(i) or (ii), or revoke the provider's Medicare billing privileges under §424.535(a)(5)(i) or (ii).

## 15.19.2.3 – Changes of Information and Ownership

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

### A. Limited

Changes of information (including additions of practice locations) submitted by providers and suppliers in the "limited" level of categorical screening shall be processed in accordance with existing instructions.

### B. Moderate and High

Unless otherwise specified in this chapter or in another CMS directive, this section 15.19.2.3(B) applies to providers and suppliers in the "moderate" or "high" level of categorical screening.

1. Addition of Practice or Administrative Location

With the exception of suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), if a provider or supplier submits a Form CMS-855 request to add a practice location (including a home health agency (HHA) branch) or submits a Form CMS-20134 request to add an administrative location that results in a new PTAN:

- The contractor shall process the application in accordance with existing instructions, and

- A site visit shall be performed consistent with section 15.19.2.1 above.

(As explained earlier, a DMEPOS supplier that is adding a new practice location falls within the "high" screening category. Additionally, an MDPP supplier that is adding an administrative location that does not result in a new PTAN falls within the existing enrollment and a site visit is not required.)

2. Change of Location

a. DMEPOS Suppliers

If a DMEPOS supplier reports a change in the physical location of an existing practice location, the National Supplier Clearinghouse shall perform a site visit in accordance with existing instructions.

b. Non-DMEPOS Suppliers

If a provider or non-DMEPOS supplier reports a change in the physical location of an existing practice location, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) in accordance with the following:

i. Ambulance service suppliers, independent clinical laboratories, independent diagnostic testing facilities, physical therapists enrolling as individuals or group practices – The contractor shall order a site visit of the changed location prior to the contractor's final decision regarding the application. This is to ensure that the location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2 of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not make its final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

ii. Community mental health centers, comprehensive outpatient rehabilitation facilities, hospices, portable x-ray suppliers, HHAs - The contractor shall order a site visit of the changed location after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to "Approved." This is to ensure that the location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2 of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

For purposes of this requirement:

- A change of location includes situations in which the provider/supplier is switching suite numbers or floors within a building. A site visit is required.

- If the provider/supplier's physical location is not changing (e.g., the provider's street name is changing but its actual office space is not), no site visit is required.

3. Change of Ownership

With the exception of DMEPOS suppliers and HHAs, if a provider or supplier

undergoes a change of ownership resulting in a new tax identification number (TIN), the contractor shall:

(1) Process the application in accordance with existing instructions, and

(2) Order a site visit through PECOS in accordance with the following:

- For ownership changes that must be approved by the RO under current CMS instructions, the site visit shall be ordered and performed after the contractor receives notice of approval from the RO but before the contractor switches the provider/supplier's enrollment record to an "Approved" status. The contractor shall not switch the provider/supplier's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

- For ownership changes that do not require RO approval under current CMS instructions, the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.

A DMEPOS supplier that is:

- Undergoing a change of ownership with a change in TIN falls within the "high" screening category.

- Undergoing a change of ownership with no change in TIN falls within the "moderate" screening category.

- Undergoing a change in TIN with no change in ownership falls within the "moderate screening category.

With respect to HHAs:

- For HHAs undergoing a change in majority ownership, the contractor shall – consistent with section 15.26.1 of this chapter – determine whether the provisions of 42 CFR §424.550(b)(1) and (2) apply. If the contractor determines that a change in majority ownership has occurred and that none of the exceptions in §424.550(b)(2) apply, the HHA must enroll as a new entity, in which case the newly-enrolling HHA will be placed into the "high" level of categorical screening. If the contractor determines that an exception does apply, the transaction will be subject to the "moderate" level of categorical screening; a site visit will be necessary.

  In addition, if: (1) the contractor determines that one of the exceptions to the 36-month rule applies, and (2) the ownership change is one that requires a recommendation for approval to the RO, the contractor shall ensure that its recommendation letter specifies:

    - That the transaction qualifies as a change in majority ownership
    - The particular exception that applies.

- For HHAs reporting an ownership change that is not a change in majority ownership as that term is defined in §424.502, the contractor shall process the change in accordance with existing instructions. A site visit is not necessary.

- For HHAs seeking to reactivate their Medicare billing privileges, the transaction shall be processed under the "moderate" level of categorical screening. A site visit will be necessary prior to the reactivation of the provider's billing privileges.

4. All Other Changes of Information

All other changes of information for providers and suppliers in the moderate or high level of categorical screening shall be processed in accordance with existing instructions.

## 15.19.2.4 – Reactivations

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

**A. Form CMS-855 Reactivations**

1. Limited

Form CMS-855 reactivation applications submitted by providers and suppliers in the "limited" level of categorical screening shall be processed in accordance with existing instructions.

2. Moderate

Form CMS-855 reactivation applications submitted by providers and suppliers in the "moderate" level of categorical screening – including existing home health agencies and suppliers of durable medical equipment, prosthetics, orthotics and suppliers (DMEPOS) – shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor's final decision regarding the application.

3. High

Form CMS-855 or Form CMS-20134 reactivation applications submitted by providers and suppliers in the "high" level of categorical screening shall be processed in accordance with the screening procedures for this category. A site

visit will therefore be necessary prior to the contractor's final decision regarding the application.

**B. Reactivation Certification Packages (RCPs)**

For RCPs (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter), a site visit is required if the provider is in the moderate or high screening category. A site visit is not required if the provider is in the limited screening category.

## 15.19.2.5 – Movement of Providers and Suppliers into the High Level

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

Under §424.518(c)(3), CMS may adjust a particular provider or supplier's screening level from "limited" or "moderate" to "high" if any of the following occur:

1. CMS imposes a payment suspension on a provider or supplier at any time within the last 10 years;

2. The provider or supplier:

    a. Has been excluded from Medicare by the Office of Inspector General; or

    b. Had its billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by:

        - Enrolling as a new provider or supplier; or
        - Obtaining billing privileges for a new practice location

    c. Has been terminated or is otherwise precluded from billing Medicaid

    d. Has been excluded from any Federal health care program

    e. Has been subject to any final adverse action (as defined in §424.502) within the previous 10 years.

3. CMS lifts a temporary moratorium for a particular provider or supplier type, and a provider or supplier that was prevented from enrolling based on the moratorium applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

CMS makes available to the contractor on a bi-monthly basis a list of current and former Medicare providers and suppliers within the contractor's jurisdiction that meet any of the criteria in subsection (1) or (2) above. Upon receipt of an initial or

revalidation application from a provider or supplier that otherwise falls within the limited or moderate screening category (and after the appropriate fee has been paid, etc.), the contractor shall determine whether the provider or supplier is on the bi-monthly "high" screening list. If the provider or supplier is not on said list, the contractor shall process the application in accordance with existing instructions. If the provider or supplier is on the list, the contractor shall process the application using the procedures in the "high" screening category unless the provider is on the list solely because he/she/it was revoked for failing to timely respond to a revalidation request. If such is the case, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead for guidance as to how the situation should be handled.

With respect to subsection (3) above, if the contractor receives an initial or new location application from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium and (b) within 6 months after the applicable moratorium was lifted, the contractor shall process the application using the procedures in the "high" screening category.

## 15.19.3 – Temporary Moratoria

**(Rev. 514, Issued: 05-02-14; Effective: 06-03-14; Implementation: 06-03-14)**

Under §424.570(a), CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. The announcement of a moratorium will be made via the Federal Register, though the contractor will be separately notified of the moratorium.

The contractor shall abide by all CMS directives and instructions issued pursuant to the imposition or lifting of a particular moratorium.

## 15.19.4 – Tracking

**(Rev. 371, Issued: 03-23-11, Effective: 03-25-11, Implementation: 03-25-11)**

In April 2011, PEOG will send to each contractor an Excel spreadsheet that the contractor shall complete and submit to its PEOG liaison via e-mail no later than the 15th day of each month. The first report will be due on May 15, 2011. The spreadsheet will contain data elements such as, but not limited to:

- Number of enrolled providers and suppliers in each risk category, broken down by provider/supplier sub-type (e.g., hospital, HHA)

- Amount of fees collected (i.e., fees that were cleared), broken down by provider and supplier type

## 15.20 – On-site Inspections and Site Verifications

**(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)**

The contractor shall not conduct site verifications to determine if a provider or supplier (including physicians and non-physician practitioners) is operational unless CMS: (1) has already issued formal guidance to do so, or (2) issues instructions directing the contractor to conduct a pre-enrollment or post-enrollment site verification.

## 15.20.1 - Site Verifications

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

(Unless otherwise stated in this chapter or in another CMS directive, this section 15.20.1 only applies to site visits/verifications that are not performed pursuant to sections 15.19.2.1 through 15.19.2.4 of this chapter.)

### A. Background

1. Operational Status

When conducting a site verification to determine whether a practice or administrative location is operational, the contractor shall make every effort to limit its site verification to an external review of the practice location. If the contractor cannot determine whether the practice location is operational based on an external review of the location, the contractor shall conduct an unobtrusive site verification by limiting its encounter with provider or supplier personnel or medical patients.

2. Determining Whether the Provider or Supplier Meets Regulatory Requirements for Its Provider or Supplier Type

When conducting a site verification to determine whether a provider or supplier continues to meet the regulatory provisions for its provider or supplier type, the contractor shall conduct its site verification in a manner which limits the disruption for the provider or supplier.

### B. Timing

Site verifications should be done Monday through Friday (excluding holidays) during their posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m. If, during the first attempt, there are obvious signs that facility is no longer operational no second attempt is required. If, on the first attempt the facility is closed but there are no obvious indications the facility is non-operational, a second attempt on a different day during posted hours of operation should be made.

### C. Documentation

When conducting site verifications to determine whether a practice location is

operational, the contractor shall:

- Document the date and time of the attempted visit and include the name of the individual attempting the visit;

- As appropriate, photograph the provider or supplier's business for inclusion in the provider or supplier's file on an as needed basis. All photographs should be date/time stamped;

- Fully document all observations made at the facility (e.g., the facility was vacant and free of all furniture, a notice of eviction or similar documentation was posted at the facility, the space is now occupied by another company); and

- Write a report of its findings regarding each site verification.

**D. Signed Declaration**

The contractor shall also include a signed declaration stating the facts and verifying the completion of the site verification. (A sample declaration is below and may be revised as necessary.) As a reminder, this declaration is only necessary for MAC-performed site visits.

**Declaration of (Name of Inspector/Investigator)**
**In the Case of _____**
**Provider/Supplier No._____**

I, **(Name of Inspector/Investigator)**, declare as follows:

1. I have personal knowledge of each of the following matters in this Declaration except to those facts alleged on information and belief, and as to those matters, I believe them to be true. I am competent to testify to the following:

2. I am an Investigator for [Insert Contractor Name]. [Insert Contractor Name] is a CMS-contracted [Intermediary/Carrier/A/B Medicare Administrative Contractor (MAC)].

3. I have been trained as an Investigator and Site Inspector by [Insert Contractor Name], and I am knowledgeable of Medicare's compliance statutes, regulations and standards for suppliers enrolled in the Medicare program. I have worked in this capacity for [Insert years] years. During this period, I have conducted over [Insert Number] site inspections of the offices and facilities of providers/suppliers; and since January [Year in which case occurs], I have conducted over [Insert Number] site inspections related to the compliance of suppliers with Medicare's requirements.

4. I prepared the attached document entitled "[Title of Document]," which is the report of my attempts to inspect Petitioner's facility. This report is a true and

accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report.

5. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed this **_(Date)__** day of **_(Month) (Year)_** in **_(City)_**, **_(State)_**.

_____

SIGNATURE OF DECLARANT

**E. Determination**

If a provider or supplier is determined not to be operational or not to be in compliance with the regulatory requirements for its provider/supplier type, the contractor shall revoke the Medicare billing privileges of the provider or supplier - unless the provider or supplier has submitted a change that notified the contractor of a change in practice location. Within 7 calendar days of CMS or the Medicare contractor determining that the provider or supplier is not operational, the Medicare contractor shall update PECOS or the applicable claims processing system (if the provider does not have an enrollment record in PECOS) to revoke billing Medicare billing privileges and issue a revocation notice to the provider or supplier. The Medicare contractor shall afford the provider or supplier applicable appeal rights in the revocation notification letter.

For non-operational status revocations, the contractor shall use either 42 CFR §424.535(a)(5)(i) or 42 CFR §424.535(a)(5)(ii) as the legal basis for revocation.

Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer operational. The Medicare contractor shall establish a 2-year enrollment bar for suppliers that are not operational.

For regulatory non-compliance revocations, the contractor shall use 42 CFR §424.535(a)(1) as the legal basis for revocation. Consistent with 42 CFR §424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider or supplier is no longer in compliance with regulatory provisions for their provider or supplier type. The Medicare contractor shall establish a 2-year enrollment bar for the providers and suppliers that are not in compliance with provisions for their enrolled provider or supplier type.

## 15.20.2 - Reserved for Future Use

**(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)**

## 15.20.3 - National Supplier Clearinghouse (NSC)
**(Rev. 424, Issued: 06-13-12, Effective: 06-19-12, Implementation: 06-19-12)**

The (NSC) shall continue to conduct onsite inspections consistent with its Statement of Work and any instructions issued by the NSC project officer.

## 15.21.7.1.1 – Model Letters for Claims Against Surety Bonds
**(Rev. 681, Issued: 10-27-16 Effective: 01-30-17, Implementation: 01-30-17)**

When making a claim against a surety bond in accordance with section 15.21.7.1 of this chapter, the contractor shall use the applicable model letter below:

### A. Letter for Overpayments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier National Provider Identifier (NPI)

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Supplier) has a $_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS - upon receiving written notice from CMS containing "sufficient evidence" as defined in the Program Integrity Manual, CMS Pub. 100-08, §15.21.7.1.A.2.(c) - the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An "unpaid claim" is defined in 42 C.F.R. §424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) has incurred an overpayment in the amount of (insert dollar amount) for (insert "a service" or "services", as applicable) performed on (insert date(s) of service). This determination was made based on specific

information about the overpayment, which is included in the attachments to this letter.

CMS has been unable to recover the full overpayment from (Supplier) using its existing recoupment procedures. (Supplier) has repaid (insert "none" or "only $_____) of the overpayment amount. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS's Durable Medical Equipment Medicare Administrative Contractor for (Supplier)'s location.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

**B. Letter for Overpayments - Supplier is No Longer Enrolled in Medicare**

Date

Surety Name
Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)

Former Supplier Address
Former Supplier NPI

Dear Surety:

(Former Supplier legal business name) was enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Former Supplier) obtained a $_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any unpaid claim for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. An "unpaid claim" is defined in 42 C.F.R. §424.57(a) as an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible.

CMS has determined that (Supplier) incurred an overpayment in the amount of (insert dollar amount) for (insert "a service" or "services", as applicable) performed on (insert date(s) of service). This determination was made based on specific information about the overpayment, which is included in the attachments to this letter.

CMS has been unable to recover the full overpayment from (Former Supplier) using its existing recoupment procedures. (Former Supplier) has repaid (insert "none" or "only $_____) of the overpayment amount.

(Former Supplier's) surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. §424.57(d)(5)(iii), the surety is liable for unpaid claims that:

(1) CMS assessed against the supplier based on overpayments that took place during the term of the bond or rider, and

(2) Were assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier's Medicare enrollment was terminated, whichever is later.

The overpayment occurred on (insert date), which was within the period of (Former Supplier)'s surety bond coverage with your company. Moreover, CMS has made its overpayment determination within the 2-year period following the date of the termination of (Former Supplier)'s Medicare enrollment. Consistent with 42 C.F.R.

§424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be (insert DME MAC), which is CMS's Durable Medical Equipment Medicare Administrative Contractor for (Supplier)'s location.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

## C. Letter for Civil Monetary Penalties and Assessments – Supplier is Still Enrolled in Medicare

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier NPI

Dear Surety:

(Supplier legal business name) is currently enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies

(DMEPOS). As a condition of its Medicare enrollment, (Supplier) is required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Supplier) has a $_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language……..

> A CMP is defined in §424.57(a) as a sum that CMS has the authority, as implemented by 42 C.F.R. §402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG)) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003) to impose on a supplier as a penalty.
>
> OR
>
> An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Supplier) on (date) in the amount of ($ _____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Supplier) using its existing collection procedures. (Supplier), however, has repaid (insert "none" or "only $_____) of this amount. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare and Medicaid Services.

Failure to make the requested payment in a timely manner may result in referrals to

the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

**D. Letter for Civil Monetary Penalties and Assessments – Supplier is No Longer Enrolled in Medicare**

Date

Surety Name
Surety Address

RE: Former Supplier Legal Business Name
Former Supplier DBA Name (if any)
Former Supplier Address
Former Supplier NPI

Dear Surety:

(Former Supplier legal business name) was enrolled in Medicare as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until (insert effective date of termination/revocation). As a condition of its Medicare enrollment, (Former Supplier) was required – under Federal regulations at 42 C.F.R. §424.57(d) - to maintain a surety bond in an amount of no less than $50,000. In accordance with this provision, (Former Supplier) obtained a $_____ surety bond with your company.

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), the surety must pay CMS – upon receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond – the amount of any civil monetary penalty (CMP) and/or assessment for which the DMEPOS supplier is responsible, up to the full penal amount of the bond. (Insert applicable language……..

A CMP is defined in §424.57(a) as a sum that CMS has the authority, as

implemented by 42 C.F.R. §402.1(c) (or the Department of Health and Human Services Office of Inspector General (OIG) has the authority, under section 1128A of the Act or 42 C.F.R. Part 1003)) to impose on a supplier as a penalty.

OR

An assessment is defined as a sum certain that CMS or the Department of Health and Human Services Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII or XXI of the Social Security Act.)

(CMS or OIG, as applicable) imposed a (CMP and/or assessment, as applicable) on (Former Supplier) on (date) in the amount of ($ _____). The (CMP and/or assessment) was imposed because (insert explanation, using information furnished by CMS or OIG).

Relevant documentation supporting our determination is attached to this letter. (Attach copy of notice of CMP/assessment that was sent to former supplier.)

(CMS or OIG, as applicable) has attempted to recover the amount of the (CMP or assessment) from (Former Supplier) using its existing collection procedures. (Former Supplier), however, has repaid (insert "none" or "only $_____) of this amount.

(Former Supplier)'s surety bond coverage with your company ended on (insert date). However, consistent with 42 C.F.R. §424.57(d)(5)(iii), the surety is liable for CMPs and/or assessments that:

(1) CMS or OIG imposed or asserted against the supplier during the term of the bond or rider, and

(2) Were imposed or assessed by CMS during the 2 years following the date that the supplier failed to submit a bond or required rider or the date that the supplier's Medicare enrollment was terminated, whichever is later.

The (CMP and/or assessment) was based on events that occurred (insert relevant date(s)), which was within the period of (Former Supplier's) surety bond coverage with your company. Moreover, CMS imposed the (CMP and/or assessment) within the 2-year period following the date of the termination of (Former Supplier)'s Medicare enrollment. Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), therefore, CMS requests that (Surety) make payment to CMS in the amount of (insert applicable amount) no later than 30 days from the date of this letter. Payment shall be made via check or money order and sent to the following address:

Contractor Name
Address
City, State and Postal ZIP Code

The payee shall be the Centers for Medicare & Medicaid Services.

Failure to make the requested payment in a timely manner may result in referrals to the United States Department of Justice for collection action, and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

**E. Surety Non-Payment Letter**

Date

Surety Name
Surety Address

RE: Supplier Legal Business Name
Supplier DBA Name (if any)
Supplier Address
Supplier National Provider Identifier (NPI)

Dear Surety:

Consistent with 42 C.F.R. §424.57(d)(5)(i)(A), we sent you a letter dated (date of letter) requesting that you make payment to CMS in the amount of (insert applicable amount) no later than 45 days from the date of said letter, a copy of which is attached. (Attach a copy of the demand letter.) As payment has not been received, this matter may be referred for further action to the United States Department of Justice for collection and/or the United States Department of the Treasury for revocation of [surety name's] authority to provide federal bonds.

Should you have any questions about this letter, please do not hesitate to contact _____ at _____. (The contractor shall identify a specific individual who

the surety can contact if questions arise.)

Sincerely,
(Name and title)

cc: Supplier Name

## 15.24.1 – Model Acknowledgement Letter

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

(This letter is optional)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference ID: (Case #, Control Number, etc.)

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date] and [is/are] currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional provider/supplier identification information: NPI, DBA Name, etc.

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM]

Sincerely,

[Name]
[Title]
[Company]

## 15.24.1.1 – Acknowledgement Letter Example

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

June 27, 2012

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

Reference ID: (Case #, Control Number, etc.)

Dear Timothy Payne, M.D.:

Your Medicare enrollment application(s) was received on June 1, 2012 and is currently being reviewed. You will receive a letter within 30 calendar days if we need any additional information.

Additional provider/supplier identification information: NPI, DBA Name, etc.

Please retain this letter in case you must submit additional information to support your application. If you have any questions, please contact our office at 555-555-1212 between the hours of 8:00 AM and 5:00 PM. Sincerely,

William Boatwright
Applications Analyst
Medicare Administrative Contractor, Inc.

## 15.24.3 – Model Rejection Letter

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

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

We received your Medicare enrollment application(s) on [date]. We are rejecting your application(s) for the following reason(s):

[List all reasons for rejection]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

In compliance with Federal regulations found at 42 CFR §424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information.

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.4 – Model Returned Application Letter

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

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

[List all reasons for return]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.5 – Model Revalidation Letter

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

## REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

**What record needs revalidating by [Due date, as Month dd yyyy]**

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

**What you need to do**

**Revalidate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

**If you need help**

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

## 15.24.5.1 – Model Revalidation Letter – CHOW Scenario Only

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

[Month Day & Year]

PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

**IMMEDIATELY** SUBMIT AN UPDATED PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE YOUR ENROLLMENT INFORMATION

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the CMS Regional Office (RO) and the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the CMS RO and the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at https://www.cms.gov/MedicareProviderSupEnroll/. Mail your completed application and all required supporting documentation to the [insert contractor

name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,
[Your Name]
[Title]

## 15.24.5.2 – Model Large Group Revalidation Notification Letter

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

[Month Day & Year]

PROVIDER/SUPPLIER GROUP NAME NPI:
ADDRESS 1, ADDRESS 2 PTAN:
CITY STATE ZIP CODE

Dear Provider/Supplier Group Name:

THIS IS **NOT** A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

## 15.24.5.3 – Model Revalidation Pend Letter

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

## PAYMENT HOLD

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

### What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

### How to resume your payments

**Revalidate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

## If you need help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

## 15.24.5.4 – Model Revalidation Deactivation Letter

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

STOPPING BILLING PRIVILEGES

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments:
[Legal Business Name] | [dba Name] |
<Repeat for other reassignments>

CMS lists the records that need revalidating at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

How to recover your billing privileges
Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help
Visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.
Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,
[Name] [Title] [Company]

## 15.24.5.5 – Model Revalidation Past-Due Group Member Letter

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

## REVALIDATION | Past-Due Group Member

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or

supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

## What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

## What your group member needs to do

**Revalidate their Medicare enrollment record**, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

## If your group member needs help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]
[Name], [Title]

## 15.24.5.6 – Model Deactivation Letter due to Inactive Provider/Supplier Letter

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

## STOPPING BILLING PRIVILEGES

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

**We have stopped your Medicare billing privileges** on [deactivation date], due to inactivity. We will not pay any claims after this date.

## What record has been deactivated

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name]
<Repeat for other reassignments>

**REBUTTAL RIGHTS:**

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]
[MAC Rebuttal Receipt Fax Number]

## How to recover your billing privileges

**Reactivate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134]for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

## If you need help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

## 15.24.5.7 – Model Return Revalidation Letter

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

## RETURN REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
    - An unsolicited revalidation is one that is received more than seven months prior to the provider/suppliers due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
    - To find the provider/suppliers revalidation due date, please go to http://go.cms.gov/MedicareRevalidation.
    - If you are not due for revalidation in the current six month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current six month period. This list with be updated monthly.

- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].

- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

**If you need help**

Visit http://go.cms.gov/MedicareRevalidation, or
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

## 15.24.8 – Denial Letter Guidance

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

- The contractor must submit one or more of 10 Primary Denial Citations as

found in x.x.x into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.

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

- Specific Denial Reasons may contain one or more of the following items:

    - A specific regulatory (CFR) citation.

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

    - Pertinent details of action(s)

- National Supplier Clearinghouse (NSC) only language. All denial letters for the NSC shall replace the 1st paragraph of the model denial letter with the following text:

  **Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR §405.800, 42 CFR §424.57, and 42 CFR §498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):**

Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

> **You may not appeal through this process the merits of any exclusion by another federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the federal agency that took the action.**

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR §410.33(g) 1 through 17. For DMEPOS providers and suppliers, the standards are found in 42 CFR §424.57(c) 1 through 30. For MDPP suppliers, the standards are found in 42 CFR §424.205(d).

## 15.24.8.1 – Model Denial Letter

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx 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. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an

administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

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. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 5, 2012

Xantippe Jones, LMFT
7824 Freudian Way
Yakima, WA 94054

Reference # (Contractor Control Number or NPI)

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. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

## 15.24.8.3 – Denial Example #2 – Criteria for Eligible Discipline Not Met

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 7, 2012

Marjorie Gosling, NP
6578 Billings Avenue
Calgary, MI 42897

Reference # (Contractor Control Number or NPI)

Dear Ms. Gosling:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse practitioners.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration.

This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Muffy McDowell
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

## 15.24.8.4 – Denial Example #3 – Provider Standards Not Met

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 1, 2012

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

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met

Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of

portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

## 15.24.8.5 – Denial Example #4 – Business Type Not Met

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 5, 2012

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

Reference # (Contractor Control Number or NPI)

Dear Mr. Bain:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners [NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Applications Analyst
Medicare Administrative Contractor, Inc.

## 15.24.8.6 – Denial Example #5 – Existing or Delinquent Overpayments

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

[Date]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):
Denial Reason 6: (42 CFR §424.530(a)(6))

**The current owner (as defined in § 424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.**

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment)

If you believe that you are able to correct the deficiencies and establish your eligibility in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized of delegated official within the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop Code (AR-18-50)
Baltimore, MD 21244

If you believe that this determination is not correct, you may request a reconsideration before a hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with you request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §489.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop Code (AR-18-50)
Baltimore, MD 21244

If you have any questions, please contact our office at (phone number) between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.8.7 – Denial Example #6 – MDPP Supplier Standards Not Met – Ineligible Coach

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

April 1, 2018

MDPP Services, Inc.
2498 Prevention Way
Koloa, Hawaii 96756

Reference # (Contractor Control Number or NPI)

Dear MDPP Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:
42 CFR §424.205(d)(3) - The MDPP supplier must not include on the roster of coaches nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria.

42 CFR §424.205(e)(v)(a) specifies that an individual with a state or federal felony conviction in the previous 10 years of any crime against persons, such as murder, rape, assault, and other similar crimes, would not meet the eligibility criteria to be an MDPP coach.

The following coach included on Section 7 of your Form CMS-20134 or its electronic equivalent meets this ineligibility criteria:

John B. Doe | DOB: June 19, 1991 | NPI: 1234567

Please see attached documentation of the felony conviction.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements and no longer have an ineligible coach on your roster. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that

you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

## 15.24.9 – Revocation Letter Guidance

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

The contractor:

- Shall submit one or more of the Primary Revocation Reasons as found in section 15.27.2 or the MDPP specific Revocation Reason outlined in 15.27.3.c into the appropriate section of the Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason;

- Shall include sufficient details to support the reason for the provider or supplier's revocation;

- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;

- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

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

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

[Month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, and if this revocation is based in whole or in part on §424.535(a)(1), you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. (Per 42 CFR §405.809, a CAP cannot be accepted for revocations based exclusively on reasons other than §424.535(a)(1). If the revocation is for multiple reasons of which one is §424.535(a)(1), the CAP will only be reviewed with respect to the §424.535(a)(1) basis for revocation.) 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:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP.

| | | |
|---|---|---|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [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. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

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:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

| | | |
|---|---|---|
| [Name of MAC] | | [Centers for Medicare & Medicaid Services] |
| [Address] | or | [Provider Enrollment & Oversight Group] |
| [City], ST [Zip] | | [7500 Security Blvd.] |
| | | [Mailstop: AR-18-50] |
| | | [Baltimore, MD 21244-1850]) |

Pursuant to 42 CFR §424.535(c), [Contractor name] is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This 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

## 15.24.9.5 – Revocation Example #3 – MDPP Supplier Use of an Ineligible Coach

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

June 16, 2018

MDPP Services, Inc
2498 Prevention Way
Koloa, HI 96756

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

Dear MDPP Services, INC:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

Revocation reason: 42 CFR §424.535(a)(1) – Not in Compliance with Medicare Requirements

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1st, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another

Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.
The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.
1234 Main St. – Attn: Hearing and Appeals, Room 510
Anytown, IL 12345

Pursuant to 42 CFR §424.205(h)(v)(B)(2), Medicare Administrative Contractor, Inc. is establishing a re-enrollment bar for a period of Three (3) years. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Joe Nail
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

## 15.24.10 – 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]

## 15.24.10.2 – Favorable Corrective Action Plan/Reconsideration Decision –Denials

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

**Provider Enrollment & Oversight Group (PEOG)**

Month XX, 2015

Provider/Supplier/Attorney
[Attn:]
Address
City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision
Legal Business Name: [provider/supplier name]
NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial effective Month XX, 201X. The initial determination letter by [MAC] was dated Month XX, 201X; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**DENIAL REASON: 42 CFR§ 424.530(a) (**fill reason 1-11**)**

***(a)*** Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:

(Reason 1-11, copied from the Reg: link)

[Insert language from the denial letter stating why they are being denied.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED**

**DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.530.

[The decision must include: A clear explanation of why PEOG is upholding the denial action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the denial, and an explanation of how the provider/supplier now meets the enrollment criteria or requirements]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**
[Enter text]

**Reconsideration:**
[Enter text]
[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**
[Enter text]

CMS grants [provider/supplier] access to the Medicare Trust Funds (by way or issuance) of a Medicare number.

This decision is a **FAVORABLE DECISION**. To effectuate this decision, CMS will direct [MAC] to allow enrollment and provide instruction, as needed, to complete the enrollment process.

Please forward any questions or concerns to providerenrollmentappeals@cms.hhs.gov.

Sincerely,

[Name]

[Signature]
Health Insurance Specialist
Centers for Medicare & Medicaid Services

cc:
[MAC]
[Provider/Supplier, if represented by an attorney]

## 15.24.10.3 – Favorable Corrective Action Plan/Reconsideration Decision –Revocations

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

**Provider Enrollment & Oversight Group(PEOG)**

Month XX, 2015

Provider/Supplier/Attorney
[Attn:]
Address
City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision
Legal Business Name: [provider/supplier name]
NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to a revocation, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**REVOCATION REASON: 42 CFR§ 425.535 (a)(fill reason 1-14)**

***(b)*** Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(Reason 1-14, copied from the Reg: link)

[Insert language from the revocation letter stating why they are being revoked.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is upholding the revocation action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the revocation, and an explanation of how the provider/supplier now meets the enrollment criteria or requirements]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**
[Enter text]

**Reconsideration:**
[Enter text]
[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**
[Enter text]

CMS grants [provider/supplier] access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

This decision is a **FAVORABLE DECISION**. To effectuate this decision, CMS will direct [MAC] to reinstate enrollment and provide instruction, as needed, to complete the enrollment process.

Please forward any questions or concerns to providerenrollmentappeals@cms.hhs.gov.

Sincerely,

[Name]

[Signature]
Health Insurance Specialist
Centers for Medicare & Medicaid Services

cc:
[MAC]
[Provider/Supplier, if represented by an attorney]

## 15.24.10.4 – Unfavorable Corrective Action Plan/Reconsideration Decision – Denials

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

**Provider Enrollment & Oversight Group(PEOG)**

Month XX, 2015

Provider/Supplier/Attorney
[Attn:]
Address
City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision
Legal Business Name: [provider/supplier name]
NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**DENIAL REASON: 42 CFR§ 424.530(a)(fill reason 1-11)**

***(c)*** Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:

(Reason 1-11, copied from the Reg: link)

[Insert language from the denial letter stating why they are being denied.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is upholding the denial action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the denial, and an explanation of how the provider does not meet the enrollment criteria or requirements]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**
[Enter text]

**Reconsideration:**
[Enter text]
[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**
[Enter text]

**CONCLUSION:**
CMS concludes that there is no error made by [MAC] in the determination of an enrollment denial. The [CAP and/or reconsideration] is/are denied and the denial is upheld. Therefore, CMS has decided not to grant you access to the Medicare Trust Funds (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, and then clicking Civil Remedies Division on the File New Appeal screen. And,
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

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.

Please forward any questions or concerns to providerenrollmentappeals@cms.hhs.gov.

Sincerely,

[Name]
[Signature]
Health Insurance Specialist
Centers for Medicare & Medicaid

cc:
[MAC]
[Provider, if represented by an attorney]

## 15.24.10.5 – Unfavorable Corrective Action Plan/Reconsideration Decision – Revocations

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

**Provider Enrollment & Oversight Group(PEOG)**

Month XX, 2015

Provider/Supplier/Attorney
[Attn:]
Address
City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision
Legal Business Name: [provider/supplier name]

NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to a revocation, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**REVOCATION REASON: 42 CFR§ 425.535 (a)(fill reason 1-14)**

> ***(d)*** Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
>
> (Reason 1-14, copied from the Reg: link)

[Insert language from the revocation letter stating why they are being revoked.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**
All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is not holding the revocation action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the revocation, and an explanation of how the provider/supplier still does not meet the enrollment criteria or requirements.]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**
[Enter text]

**Reconsideration:**
[Enter text]
[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**
[Enter text]

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, and then clicking Civil Remedies Division on the File New Appeal screen. And,
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

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.

Please forward any questions or concerns to providerenrollmentappeals@cms.hhs.gov.

Sincerely,

[Name]

[Signature]
Health Insurance Specialist
Centers for Medicare & Medicaid Services

cc:
[MAC]
[Provider/Supplier, if represented by an attorney]

## 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.

## 15.24.12 – Model Identity Theft Prevention Letter

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

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at www.cms.hhs.gov/MedicareProviderSupEnroll.
We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,
[Name]
[Title]
[Company]

## 15.24.13 – Identity Theft Prevention Example

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

May 16, 2012

Joseph Bock, M.D.
1234 Maple Lane
Anywhere ME 12931

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

Dear Dr. Bock:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

Joseph Bock, M.D.
4321 Oak Drive
Anywhere ME 12910

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-

For-Service contact information can be found at
www.cms.hhs.gov/MedicareProviderSupEnroll.

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at 555-555-1212 between the hours of 8 A.M. and 5 P.M. and refer to your application(s) reference number 123456789.

Sincerely,
Boris Battles
Security Analyst
Medicare Administrative Contractor, Inc.

## 15.24.14 – Model Documentation Request Letter

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

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

[Under 42 CFR § 424.516(f)(1, a provider or supplier who furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service; and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.]

Or

[Under 42 CFR § 424.516(f) (2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.]

Or

[Under 42 CFR §424.205(g), an MDPP supplier is required to maintain documentation for 10 years from the date of services and to provide access to that documentation pursuant to a CMS or Medicare contractor request.]

Consistent with [§ 424.516(f) [(x)] or §424.205(g)], please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

(etc.)

The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

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

Failure to timely submit this documentation may result in the revocation of your Medicare billing privileges pursuant to 42 CFR § 424.535(a) (10).

[Name]
[Title]
[Company]
[Title]
[Company]

## 15.24.15 – Model Deactivation Letter

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)[1-2]

[Specific reason for the deactivation of the provider/supplier's Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[MAC Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[MAC Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [MAC Name] has not received a Medicare enrollment application reporting this change in ownership.)

**REBUTTAL RIGHTS:**

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name] [Title] [Company]

## 15.24.16 – Model Opt-out Letters

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

The MACs shall use the model letters in this section to respond to eligible practitioners' opt-out affidavits, request additional documentation, approve opt out affidavits and acknowledge the cancelation or early termination of an opt-out. The

MACs shall not use these model letters to respond to Medicare enrollment applications or other correspondence. The MACs may issue the Model Opt-out Development Letter via fax, e-mail or mail to the eligible practitioner.

## 15.24.16.1 – Opt-out Affidavit Development Letter

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

MACs shall use the following letter to request missing information from an eligible practitioner that wishes to opt-out of Medicare. This letter should be sent only one time and include a request for all missing information. The MAC may select the response type, either via mail, fax or email.

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner]:

[Insert MAC] requires the following information to complete the processing of your Medicare opt-out affidavit:

[Specify information needed]

Submit the requested information within 30 calendar days of the postmark date of this letter [to the address listed below, via fax to (###-###-####), or via email to (enter PE analyst's email address here)]. We may reject your opt-out affidavit if you do not furnish the requested information within this timeframe.

[Name of MAC]

[Address]

[City], [ST]
[Zip]

Attach a copy of this letter with your revised opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM. ]

Sincerely,

[Name]

[Title]
[Company]

## 15.24.16.2 – Opt-out Rejection Letter

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

In the event that an eligible practitioner does not respond timely or does not respond with needed information to complete an opt-out affidavit, the MACs shall issue this rejection letter.

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

[Insert MAC] is rejecting your Medicare opt-out affidavit, received on [insert date], for the following reason(s):

[List all reasons for rejection:]

To resubmit your opt-out affidavit include all information needed to process your opt-out request. Additional information on submitting a complete opt-out affidavit can be found at: [enter MAC website address].

Return the completed opt-out affidavit to:

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

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.3 – Opt-out Return Letters
**(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

Opt-out affidavits should only be returned for the following reasons:

1. The eligible practitioner requesting to opt-out of Medicare is not appropriately licensed by the state,
2. The practitioner is a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.),
3. The opt-out affidavit is filed with an incorrect MAC, or
4. The eligible practitioner decides not to opt out of Medicare while their opt-out affidavit is still in process, but not yet approved by the MAC.

MACs shall issue the specific letter for the return reason.

## 15.24.16.3.1 – Opt-out Return Letter – Unlicensed Eligible Practitioner
**(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], as you are not licensed by the state for the specialty type you indicated on your opt-out affidavit.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.3.2 – Opt-out Return Letter – Ineligible Practitioner
**(Rev. 926; Issued: 11-22-19; Effective: 12-24-19; Implementation: 12-24-19)**

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you indicated a specialty that is ineligible to opt-out (e.g., Chiropractic Medicine, Physical Therapy, Occupational Therapy, etc.) of Medicare.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.3.3 – Opt-out Return Letter – Submitted to Incorrect MAC

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because your opt-out affidavit was filed with an incorrect Medicare Administrative Contractor for the state that you are located in. Your affidavit should be resubmitted to the appropriate contractor for processing.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.3.4 – Opt-out Return Letter – Withdraw of Affidavit During Processing

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.4 – Opt-out Affidavit Approval Letters

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

The MACs shall issue an Opt-out Affidavit Approval ~~this~~ model letter when approving an opt-out affidavit and PECOS has been updated with the affidavit information. The approval letter shall be issued for the following reasons:

1. Approved Opt-Out, Eligible Practitioner May Order & Refer
2. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (OIG Exclusion)
3. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Ineligible Specialty)
4. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Did Not Elect to Order & Refer)

5. Approved Opt-Out, Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

The Opt-out approval letter shall include:

- The eligible practitioner's personal information:
    - Name,
    - Address,
    - NPI,
    - Specialty, and
    - Eligibility to order and refer.
- The eligible practitioner's opt-out effective date.
- The date that the eligible practitioner can submit a request to cancel their opt-out affidavit (at least 30 days prior to the end-date of their current opt-out period) ~~and~~
- The date the eligible practitioner can terminate his/her opt-out early (if they are eligible to so, no later than 90 days after the effective date) of the eligible practitioner's initial 2-year opt-out period.

## 15.24.16.4.1 – Opt-out Affidavit Approval Letter – Eligible Practitioner Approved to Order & Refer

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|---|---|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are eligible to Order and Refer |

Effective Date: [Effective date]

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

## APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
    - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for

reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.4.2 – Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Excluded by the OIG)

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|---|---|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You have been excluded by the OIG (and even if you have or have not obtained a waiver according to 42 CFR §1001.1901(c)), you may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

## APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.

- If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.4.4 – Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Did Not Elect to Order and Refer)

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|---|---|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [NPI] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries as you did not elect to be and ordering and referring practitioner on your opt-out affidavit.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

## APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.

- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
    - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.4.5 – Opt-out Affidavit Approval Letter – Eligible Practitioner May Not Order & Refer (Eligible Practitioner Does Not Have an NPI)

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] [approved or updated] your Medicare opt-out affidavit.

Opt-out Affidavit Information:

| | |
|---|---|
| Eligible Practitioner Name: | [Name] |
| Address of File: | [Address, City, State, Zip] |
| National Provider Identifier (NPI): | [Not Provided] |
| Specialty: | [Specialty] |
| Ordering and Referring: | You are not eligible to Order and Refer* |
| Effective Date: | [Effective date] |

* You may opt-out of Medicare, but you are not permitted to order and refer items and services to Medicare beneficiaries, as you have not obtained an NPI.

Your opt-out will automatically renew every 2 years.

Since you are opting out for the very first time, you have a one-time, 90 day period to change your mind about opting out. If you decide to terminate during this 90 day period, you must submit your request, in writing and signed, no later than [Month DD, YYYY]. After this 90 day period ends, you can only cancel the opt-out at the end of a 2 year opt-out period. If you were unable to submit a termination request, you may appeal after the 90 day period ends. Please follow the Appeal Rights sections below.

To cancel opt-out, you must submit a cancellation request in writing and signed at least 30 days prior to the end of the opt-out period. For example, if you decide you want to cancel your opt-out at the end of this opt-out period, you must submit your cancellation request before [Month DD, YYYY].

**APPEAL RIGHTS**

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter (or within 60 calendar days after the 90-day period to terminate ends) and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
    - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.5 –Opt-out Renewal Alert Letter

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

The MACs shall issue the following letter, informing the eligible practitioner that the opt-out is due to be automatically renewed.

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear Eligible Practitioner Name:

We are writing to inform you that your opt-out will be automatically renewed for a new 2 year opt-out period, on [Month, DD, YYYY].

To cancel your opt-out in the future, you will need to submit a cancellation request at least 30 days prior to the end of your opt-out period, which is [Month DD, YYYY].

If your intention is to cancel your opt-out, but fail to submit a cancellation notice to us, please see the Appeal Rights section of this letter below.

**APPEAL RIGHTS**

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the auto-renewal date and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.

- If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.6 – Opt-out Affidavit Termination Letter

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

If an eligible practitioner timely terminates his/her initial opt-out, the MACs shall acknowledge this action by using this model letter.

Month DD, YYYY

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] completed your request to terminate your Medicare opt-out affidavit.

If you have not previously enrolled with Medicare and want to enroll as a Medicare billing provider or for the sole purpose of ordering and referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

## APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
    - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.24.16.7 – Opt-out Affidavit Cancel Letter

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

If an eligible practitioner timely submits an opt-out cancellation request, the MACs shall acknowledge this action by using this model letter.

Month DD, YYYY

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] completed your request to cancel your Medicare opt-out affidavit.

Your opt-out status will be canceled effective [Month DD, YYYY].

Want to enroll as a Medicare billing provider or for the sole purpose of ordering of referring? Submit the appropriate Provider Enrollment Chain and Ownership System (PECOS) application or paper CMS-855 form.

## APPEAL RIGHTS

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. Reconsideration requests must:

- Be requested in writing within 60 calendar days of the postmark date of this letter and mailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the eligible practitioner or an authorized legal representative.
    - If the authorized legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the legal representative.
    - If the authorized legal representative is not an attorney, the eligible practitioner must file written notice of the appointment of its representative with the submission of the reconsideration request.

Eligible practitioners may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

Send reconsideration requests to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore MD 21244-1850

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]
[Title]
[Company]

## 15.25 – Appeals Process

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

### A. Background

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privileges are revoked may request an appeal of that determination. Change of information request denials, reassignment denials, and effective date determinations for initial enrollments may also be appealed.

This appeal process applies to all providers and suppliers - not merely those defined in 42 CFR Part 498 - and ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a reconsideration decision to an administrative law judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers may thereafter seek review by the Departmental Appeals Board (DAB) and may then request judicial review.

### B. Notification Letters for Denials and Revocations

If a Medicare contractor finds a legal basis for denying an application - and, if applicable under section 15.8.4 of this chapter, receives approval from the Provider Enrollment & Oversight Group (PEOG) for said denial - the contractor shall deny the application and notify the provider or supplier by letter. The denial letter shall contain:

- A legal (i.e., regulatory) basis for each reason for the denial;

- A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;

- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;

- Procedures for submitting a corrective action plan (CAP); and

- Complete and accurate information about the provider or supplier's further appeal rights.

Similarly, when a Medicare contractor discovers a basis for revoking a provider or supplier's enrollment - and, if applicable under section 15.27.2 of this chapter, receives approval from PEOG for the revocation - the contractor shall revoke billing privileges and notify the provider or supplier by letter. The revocation letter shall contain:

- A legal (i.e., regulatory) basis for each reason for revocation;

- A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;

- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;

- The effective date of the revocation (see section 15.27.2(C) of this chapter for more information);

- Procedures for submitting a CAP; and

- Complete and accurate information about the provider or supplier's further appeal rights.

## 15.25.1 - Appeals Involving Non-Certified Suppliers
**(Rev. 440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)**

Sections 15.25.1.1 through 15.25.1.3 below apply to:

- Individuals and solely-owned entities completing the Form CMS-855I

- Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)

- Suppliers completing the Form CMS-855B, with the exception of ambulatory surgical centers and portable x-ray suppliers

## 15.25.1.1 – Corrective Action Plans (CAPs)
**(Rev. 676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)**

**A. Requirements and Submission of CAPs**

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its

enrollment. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;

(4) For revocations, be based on §424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than §424.535(a)(1) shall not be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) If the supplier submits a CAP that does not comply with this paragraph, the contractor shall notify the supplier via letter or e-mail that it cannot be considered. (If multiple grounds are involved of which one is (a)(1), the contractor shall:

- Only consider the portion of the CAP pertaining to (a)(1), and

- Notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under §405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.)

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above:

- Denials - The contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.

- Revocations – The contractor shall not contact the supplier for the missing information or documentation. It shall simply deny the CAP. (Under §405.809(a)(2), the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.)

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP.

**B. Processing and Approval of CAPs**

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements. Consider the following examples:

*1.* Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

*2.* Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

**C. Concurrent Submission of CAP and Reconsideration Request**

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of

rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It cannot be appealed.
- The contractor shall notify the supplier of the denial via letter.
- The supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if submitted, shall be processed.

## 15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers

**(Rev. 734; Issued: 07-28-17; Effective: 06-27-17; Implementation: 06-27-17)**

**NOTE:** This section 15.25.1.2 does not apply to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4), §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3). Such reconsiderations are addressed in section 15.25.2.2 below.

### A. Timeframe for Submission

A supplier that wishes to request a reconsideration must file its request in writing with the Medicare contractor within 60 days from the supplier's receipt of the notice of denial or revocation to be considered timely filed. Per 42 CFR §498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. A reconsideration request submitted on the 65th day that falls on a weekend or holiday shall still be considered timely filed. The date on which the contractor receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, the reconsideration HO shall make a finding of good cause before taking any other action on the appeal. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

**B. Signatures**

The reconsideration request must be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(**NOTE:** The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.)

For DMEPOS suppliers, the request must be signed by the authorized official, delegated official, owner or partner.

**C. Contractor's Receipt of Reconsideration Request**

Upon receipt of a reconsideration request, the hearing officer (HO) shall send a letter to the supplier to acknowledge receipt of its request. In his or her acknowledgment letter, the HO shall advise the requesting party that the reconsideration will be conducted and a determination issued within 90 days from the date of the request. The HO shall include a copy of the acknowledgment letter in the reconsideration file.

**D. Reconsideration Determination**

If a timely request for a reconsideration is made, the reconsideration shall be conducted by a HO or senior staff having expertise in provider enrollment and <u>who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination</u>. In other words, separate individuals must conduct/perform/review the denial/revocation, the CAP, and the reconsideration. This is to ensure completely independent reviews of all three transactions.

The HO must hold an on-the-record reconsideration and issue a determination within 90 days of the date of the appeal request.

Consistent with 42 CFR §498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the HO's decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,

- The findings on which the initial determination was based,

- The evidence considered in making the initial determination, and

- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

If the appealing party has additional information that it would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an administrative law judge specifically allows the party to do so under 42 CFR §498.56(e).

**E. Issuance of Reconsideration Decision**

The HO shall issue a written decision within 90 days of the date of the request. He/she shall: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the supplier. The reconsideration letter shall include:

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;

- A summary of the documentation that the supplier provided;

- A clear explanation of why the HO is upholding or overturning the denial or revocation action in sufficient detail for the supplier to understand the HO's decision and, if applicable, the nature of the supplier's deficiencies;

- If applicable, the regulatory basis to support each reason for the denial or revocation;

- If applicable, an explanation of how the supplier does not meet the enrollment criteria or requirements;

- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the addresses to which the written appeal must be mailed or e-mailed; and

- Information the supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

If the HO overturns the contractor's decision, the contractor shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable "backbilling" restrictions. (See section 15.17 of this chapter for more information.) The contractor shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System. For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse.

### F. Withdrawal of Reconsideration Request

The supplier or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with the Medicare contractor. If the contractor receives such a request, it shall send a letter or e-mail to the supplier acknowledging the receipt of the request and advising that the reconsideration action will be terminated.

## 15.25.1.3 – Additional Appeal Levels

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

### A. Administrative Law Judge (ALJ) Hearing

CMS, a Medicare contractor, or a supplier dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

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

(ALJ requests can also be submitted electronically at https://dab.efile.hhs.gov/.)

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the supplier, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

The following are examples of information the Medicare contractor may be asked to provide:

- A copy of the initial determination letter.
- A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.
- The HO's decision; including the provider's CAP or reconsideration request.
- A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.
- All background information and investigative data that the HO used to make their decision. Including any on-site visit reports; the contractor's recommendation for administrative action based on the on-site visit;
- Contact information for the person(s) who signed both the revocation and reconsideration letters.
- This is not an exhaustive list.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns, modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the settlement or ALJ decision no later than 5 business days from the date it received PEOG's specific instructions.

**B. Departmental Appeals Board (DAB) Hearing**

CMS or a supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the contractor of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.
The contractor shall complete all steps associated with the DAB decision no later than 5 business days from the date it received PEOG's specific instructions.

**C. Judicial Review**

A supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed within 60 days from receipt of the notice of the DAB's decision.

## 15.25.2 - Appeals Involving Certified Providers and Certified Suppliers

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

Sections 15.25.2.1 through 15.25.2.3 below apply to:

- Providers and suppliers completing the Form CMS-855A

- Ambulatory surgical centers

- Portable x-ray suppliers

- Also, section 15.25.2.2 applies to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4), §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3), regardless of provider or supplier type.

## 15.25.2.1 – Corrective Action Plans (CAPs)

**(Rev. 676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)**

**A. Submission of CAPs**

The CAP process gives a provider or supplier (hereinafter collectively referred to as "providers") an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its enrollment. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(4) For revocations, be based on §424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) cannot be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) CMS' Provider Enrollment & Oversight Group (PEOG), which processes all CAPs, will notify the provider if a CAP cannot be accepted.

CAP requests must be sent to the following address:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR 18-50
Baltimore, MD 21244-1850

If the contractor inadvertently receives a CAP request, it shall immediately forward it to PEOG at this address or, if possible, to the following PEOG mailbox:

providerenrollmentappeals@cms.hhs.gov.

Also:

- PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

- The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

**B. Processing and Approval of CAPs**

PEOG will process a CAP within 60 days. During this period, PEOG will not toll the filing requirements associated with a reconsideration request.

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and permit or restore enrollment (as applicable), and (2) notify the provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

If the CAP is denied:

- It cannot be appealed.

- PEOG will notify the provider or supplier of the denial via letter.

- The provider or supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.

- The reconsideration request, if submitted, will be processed.

## 15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

This section 15.25.2.2 also applies to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4) or §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14), and reconsiderations of denials based wholly or partially on §424.530(a)(3), regardless of provider or supplier type.

**A. Timeframe for Submission**

A provider that wishes to request a reconsideration must submit its request, in writing, to CMS' PEOG within 60 days from the supplier's receipt of the notice of

denial or revocation to be considered timely filed. Per 42 CFR §498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. The mailing address is:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
7500 Security Boulevard
Mailstop AR-18-50
Baltimore, MD 21244-1850

PEOG will extend the filing period an additional 5 days to allow for mail time. A reconsideration request submitted on the 65th day that falls on a weekend or holiday will still be considered timely filed. The date on which PEOG receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, PEOG will make a finding of good cause before taking any other action on the appeal. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

**B. Signatures**

A reconsideration request must be signed by an authorized official, delegated official, or legal representative of the provider. The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

**C. Receipt of Reconsideration Request**

Upon receipt of a reconsideration request, PEOG will send a letter to the provider to acknowledge receipt of the request. In its acknowledgment letter, PEOG will advise the provider that the reconsideration will be conducted and a determination issued within 90 days from the date of the request. PEOG will include a copy of the acknowledgment letter in the reconsideration file.

If the contractor inadvertently receives a reconsideration request from a certified

provider or certified supplier, it shall immediately forward it to PEOG at this address or, if possible, to the following PEOG mailbox: providerenrollmentappeals@cms.hhs.gov.

**D. Reconsideration Determination**

As already stated, if a timely request for a reconsideration is made, PEOG will consider the request and issue a determination within 90 days of the request.

The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

The contractor shall work with and provide PEOG with all necessary documentation.

The following are examples of information the Medicare contractor will be asked to provide:

- A copy of the initial determination letter.
- A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.
- A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.
- This is not an exhaustive list.

The contractor shall supply PEOG with all requested documentation within 5 business days.

If the appealing party has additional information that it would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an administrative law judge specifically allows the party to do so under 42 CFR §498.56(e).

PEOG may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

**E. Issuance of Reconsideration Decision**

PEOG will issue a written decision within 90 days of the date of the request. It will: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the provider or the individual who signed the reconsideration request. The reconsideration letter will include:

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;

- A summary of the documentation that the provider furnished;

- A clear explanation of why PEOG is upholding or overturning the denial or revocation action in sufficient detail for the provider to understand PEOG's decision and, if applicable, the nature of the provider's deficiencies;

- If applicable, the regulatory basis to support each reason for the denial or revocation;

- If applicable, an explanation of how the provider does not meet the enrollment criteria or requirements;

- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the address to which the written appeal must be mailed or e-mailed; and

- Information that the provider must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and issue or restore billing privileges (as applicable), and (2) notify the provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

**F. Withdrawal of Reconsideration Request**

The provider or the individual who signed the reconsideration request may withdraw its request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with PEOG at the address in (A) above.

## 15.25.2.3 – Additional Appeal Levels
**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

### A. Administrative Law Judge (ALJ) Hearing

CMS, a Medicare contractor, or a provider dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

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

(ALJ requests can also be submitted electronically at https://dab.efile.hhs.gov/.)

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

The following are examples of information the Medicare contractor may be asked to provide:

- A copy of the initial determination letter.

- A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.

- The HO's decision; including the provider's CAP or reconsideration request.

- A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.

- All background information and investigative data that the HO used to make their decision. Including any on-site visit reports; the contractor's recommendation for administrative action based on the on-site visit;

- Contact information for the person(s) who signed both the revocation and reconsideration letters.

- This is not an exhaustive list.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns, modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the settlement or ALJ decision no later than 5 business days from the date it received PEOG's specific instructions.

**B. Departmental Appeals Board (DAB) Hearing**

The CMS or a provider dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is

admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the contractor of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the DAB decision no later than 5 business days from the date it received PEOG's specific instructions.

### C. Judicial Review

A provider dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed within 60 days from receipt of the notice of the DAB's decision.

## 15.26.2 – Capitalization

**(Rev. 362, Issued: 12-17-10, Effective: 01-01-11, Implementation: 01-01-11)**

### A. Background

Effective January 1, 2011, and pursuant to 42 CFR §489.28(a) and §424.510(d)(9), an HHA entering the Medicare program - including a new HHA as a result of a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds, which we term initial reserve operating funds, at (1) the time of application submission, and (2) all times during the enrollment process, to operate the HHA for the three-month period after Medicare billing privileges are conveyed by the Medicare contractor (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the 3-month period following the conveyance of Medicare billing privileges.

### B. Points of Review

At a minimum, the contractor shall verify that the HHA meets the required amount of capitalization:

1. Prior to making its recommendation for approval;

2. After a recommendation for approval is made but before the RO review process is completed;

3. After the RO review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and

4. During the 3-month period after the contractor conveys Medicare billing privileges to the HHA.

The HHA must submit proof of capitalization within 30 calendar days of being requested to do so by the contractor. Should the HHA fail to furnish said proof and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to §424.530(a)(8)(i) or (ii), as applicable. If billing privileges have been conveyed, the contractor shall revoke the HHA's billing privileges per §424.535(a)(11).

Should the contractor believe it is necessary to verify the HHA's level of capitalization more than once within a given period, e.g., more than once between the time a recommendation is made and the completion of the RO review process – the contractor shall seek approval from its DPSE liaison.

**C. Determining Initial Reserve Operating Funds**

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR §489.28(a) if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of 3 or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first 3 months of operation--or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs--whichever is greater.

The contractor shall determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least 3 HHAs that the contractor serves that are comparable to the HHA that is seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- Geographic location and urban/rural status;
- Number of visits;
- Provider-based versus free-standing status; and
- Proprietary versus non-proprietary status.

The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by

the projected visits for the first 3 months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

**D. Proof of Operating Funds**

The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, must include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA.

In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds.

As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

**E. Borrowed Funds**

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds,

including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

**F. Line of Credit**

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

**G. Documents**

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the provider:

- A document outlining the provider's projected budget – preferably, a full year's budget broken out by month
- A document outlining the number of anticipated visits - preferably a full year broken out by month
- An attestation statement from an officer of the HHA defining the source of funds
- Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)
- Letter from officer of the bank attesting that funds are available
- If available, audited financial statements

The contractor shall also ensure that the capitalization information in section 12, of the CMS-855A is provided.

## 15.26.3 – Additional Home Health Agency (HHA) Review Activities

**(Rev. 492, Issued: 12-06-13, Effective: 01-07-14, Implementation: 01-07-14)**

As stated in section 15.26.2(B)(3) of this chapter, the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this "post-RO review" period.

To confirm that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement, the contractor shall also – during the post-RO review period ensure that each entity and individual listed in sections 2, 5 and 6 of the HHA's Form CMS-855A application is again reviewed against the Medicare Exclusion Database (MED) and the System for Award Management (SAM) (formerly the General Services Administration (GSA) Access Management System). This activity applies: (1) regardless of whether the HHA is provider-based or freestanding, and (2) only to initial enrollments.

The capitalization and MED/SAM re-reviews described above shall be performed once the RO notifies the contractor via e-mail that the RO's review is complete. (Per sections 15.4.1.6 and 15.19.2.2 of this chapter, a site visit will be performed after the contractor receives the tie-in/approval notice from the RO but before the contractor conveys Medicare billing privileges to the HHA.) If:

**a. The HHA is still in compliance** (e.g., no owners or managing employees are excluded, capitalization is met):

1. The contractor shall notify the RO of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.

2. The RO will: (1) issue a CMS Certification Number (CCN), (2) sign a provider agreement, and (3) send a tie-in notice or approval letter to the contractor. Per section 15.7.7.2.1 of chapter 15, the contractor shall complete its processing of the tie-in notice/approval letter within 45 calendar days of receipt (during which time a site visit will be performed).

**b. The HHA is not in compliance** (e.g., capitalization is not met):

1. The contractor shall deny the application in accordance with the instructions in this chapter and issue appeal rights. (The denial date shall be the date on which the contractor completed its follow-up capitalization and MED/SAM reviews.)

2. Notify the RO of the denial via e-mail. (PEOG, not the RO, will handle any CAP or appeal related to the contractor's denial.)

While, therefore, the process of enrolling certified suppliers and certified providers other than HHAs remains the same (i.e., recommendation is made to State/RO, after which the RO sends tie-in notice to contractor, etc.), the HHA process contains additional steps – specifically, Steps 4 and 5, as outlined below:

1. Contractor processes incoming HHA application and either (1) denies application, or (2) recommends approval to State/RO.

2. State performs survey (if applicable) and makes recommendation to RO.

3. If State recommends approval and RO concurs, RO will – instead of issuing CCN, signing provider agreement and sending tie-in notice/approval letter to contractor at this point, as is done with other certified provider and certified supplier applications – notify contractor that its review is complete.

4. Upon receipt of RO's notification, contractor will perform capitalization and MED/SAM reviews discussed in sections 15.26.2 and 15.26.3 of this chapter.

5. Once contractor completes its review, it will notify RO as to whether HHA is still in compliance with enrollment requirements.

## 15.27 – Deactivations and Revocations

**(Rev. 354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)**

If circumstances warrant, a fee-for-service contractor shall deactivate or revoke a provider or supplier's Medicare billing privileges under certain circumstances. Deactivation or revocation of Medicare billing privileges will not impact a provider or supplier's ability to submit claims to non-Medicare payers using their National Provider Identifier.

## 15.27.1 – Deactivations and Reactivations

**(Rev. 474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)**

## 15.27.1.2 – Reactivations

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

Sections 15.27.1.2.1 through 15.27.2.2 below discuss the requirements for reactivating a provider or supplier's billing privileges.

If the contractor approves a provider or supplier's reactivation application or reactivation certification package (RCP) for a Part B non-certified supplier, the reactivation effective date shall be based on the date the contractor received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the contractor shall issue a new Provider Transaction Access Number (PTAN) unless otherwise stated in this chapter.

Contractors shall grant retrospective billing privileges in accordance with Section 15.17(B) for reactivating providers and suppliers, unless otherwise stated in this chapter. This includes providers that were deactivated for not responding to a revalidation request.

With the exception of HHAs, reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or

participation agreement. Per 42 CFR § 424.540(b)(3)(i), an HHA must undergo a new State survey or obtain accreditation by an approved accreditation organization before its billing privileges can be reactivated. (See section 15.26.3 of this chapter for more information.)

## 15.27.1.2.1 – Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim

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

**A. Background**

To reactivate its billing privileges, a provider or supplier deactivated for failing to timely notify the contractor of a change of information (see section 15.27.1.1(A) above) must either:

1. Submit a complete Medicare enrollment application, or

2. Recertify that its enrollment information currently on file with Medicare is correct.

**B. Certification Option**

1. General Requirements

To utilize option (A)(2) above, the provider or supplier must submit to the contractor (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 or Form CMS-20134 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, and (c) a letter certifying as to the data's accuracy. The letter must:

(i) Be on the provider or supplier's letterhead.

(ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.

(iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.

(iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).

(v) Contain the following language:

For Individual Practitioners

"I, _____, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them."

A separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record (and the PTANs in that record) the provider or supplier seeks to have reactivated. To illustrate, suppose a supplier has three separate enrollments it wants to reactivate. Each enrollment has its own PECOS enrollment record. Two of the records have one PTAN; the third record contains two PTANs. The supplier must submit three separate PECOS Web printouts, three separate certification statements, and three separate letters. (The letter pertaining to the third enrollment record must list both PTANs.) The certification statement and letter should be attached to the PECOS Web printout to which it pertains – meaning, per our example, that there would be three separate "reactivation certification packages" (RCPs). All RCPs must be submitted via mail. They cannot be faxed or e-mailed.

The provider or supplier cannot utilize the certification option and must submit a complete Form CMS-855 or Form CMS-20134 application if:

- There is any information in the provider or supplier's PECOS Web enrollment record that is not correct.

- The provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS).

- The provider or supplier cannot otherwise produce a valid RCP.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (B)(1) above. If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).

- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).

- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

- Reserves the right to request a full Form CMS-855 or Form CMS-20134 application if the contractor has reason to believe that any data in the provider's enrollment record is inaccurate or outdated. However, it shall obtain the approval of its CMS Provider Enrollment Business Function Lead (PEBFL) before making this request.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.1(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider is operational per the site visit, and (5) for HHAs, has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (As stated earlier, though, rejection is appropriate if the provider does not adequately respond to the provider's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

## 15.27.1.2.2 – Reactivations - Deactivation for Non-Submission of a Claim

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

To reactivate its billing privileges, a provider or supplier deactivated for non-billing must recertify that its enrollment information currently on file with Medicare is correct. This section discusses this requirement.

## A. All of Provider's Data in Enrollment Record Is Correct

1. General Requirements

If all of the data in the provider or supplier's enrollment record is correct, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 or Form CMS-20134 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (c) the claim data described in section 15.27.1.2.3(B) of this chapter, and (d) a letter certifying as to the data's accuracy. The letter must:

(i) Be on the provider or supplier's letterhead.

(ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.

(iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.

(iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).

(v) Contain the following language:

<u>For Individual Practitioners</u>

> "I, _____, certify that all of the information contained in Medicare enrollment record <u>(the record's PAC ID number)</u> is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

<u>For Authorized/Delegated Officials</u>

"I, _____, in my capacity as an authorized or delegated official of <u>(Provider/Supplier),</u> certify on behalf of <u>(Provider/Supplier)</u> that all of the

information contained in (Provider/Supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (Provider/Supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them."

As explained in section 15.27.1.2.2(A), a separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All such "reactivation certification packages" (RCPs) must be submitted via mail. They cannot be faxed or emailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (A)(1) above.

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).

- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).

- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(A), (2) remains appropriately licensed and/or certified, (3) none

of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, and (5) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

**B. Some of Provider's Data in Enrollment Record Is Incorrect**

1. General Requirements

If any data in the provider or supplier's enrollment record is incorrect, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) applicable hard-copy page(s) of the Form CMS-855 or Form CMS-20134 containing the corrected information (e.g., new section 8 reporting a change to the billing company address), (c) a certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (d) the claim data described in section 15.27.1.2.3(B) of this chapter, and (e) a letter certifying as to the rest of the enrollment data's accuracy. The letter must:

(i) Be on the provider or supplier's letterhead.

(ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), NPI, and PTAN(s).

(iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.

(iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).

(v) Contain the following language:

<u>For Individual Practitioners</u>

> "I, _____, certify that - with the exception of <u>(list the data elements that are currently incorrect and are being updated via the submitted Form CMS-855 pages)</u> - all of the information currently contained in Medicare enrollment record <u>(the record's PAC ID number)</u> is truthful and accurate. I understand that

by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted [Form CMS-855 or Form CMS-20134] pages) - all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them."

As explained in section 15.27.1.2.2(B), a separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All RCPs must be submitted via mail. They cannot be faxed or emailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (B)(1) above.

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the letter does not identify the information in the enrollment record that is incorrect; (4) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (5) the certification statement or letter is undated; (6) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the MED and the SAM.

- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).

- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

- Process the changed information in accordance with the instructions in this chapter. The entire RCP transaction (including the changed data) shall, however, be processed as a revalidation.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, (5) all of the changed information can be processed to approval, and (6) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its (PEBFL) for guidance.

### C. PECOS Web Printout

If the provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS) or cannot otherwise submit a valid RCP, it must submit a complete Form CMS-855 or Form CMS-20134 application in order to reactivate its Medicare billing privileges.

## 15.27.1.2.3 – Reactivations – Miscellaneous Policies

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

### A. Full Enrollment Applications

1. For providers that were deactivated for non-billing, the provider may submit a complete Form CMS-855 or Form CMS-20134 enrollment application in lieu of an RCP. The application may be submitted via paper or PECOS Web.

2. For Form CMS-855 or Form CMS-20134 reactivation applications, the timeliness requirements in sections 15.6.1 et seq., pertaining to initial enrollment applications apply. The contractor shall – unless a CMS instruction directs otherwise - validate all of the information on the application just as it would with an

initial application.

3. Unless stated or indicated otherwise:

- The term "Form CMS-855 revalidations" or "Form CMS-20134 revalidations" as used in this chapter 15 only includes Form CMS-855 or Form CMS-20134 revalidation applications. It does not include RCPs.

- The term "revalidation" as used in this chapter 15 includes Form CMS-855 or Form CMS-20134 revalidation applications and RCPs.

### B. Claims

For RCP submissions, the provider must also furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. Alternatively, the provider may include in its RCP letter the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.

### C. Development

If the initial RCP is incomplete or inadequate and the contractor initiates development procedures, the following principles apply:

- The provider may submit the requested documentation to the contractor via scanned email, fax or mail.

- If there are deficiencies in the RCP letter, the provider must submit (1) a new letter, and (2) a newly-signed and dated certification statement (The certification statement may be submitted by the provider via scanned email, fax or mail). The provider cannot mark-up the previous letter and resubmit it.

## 15.27.2 – Revocations

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

### A. Revocation Reasons

(Except as described in section 15.27.2(B)(2) below, the contractor shall not issue any revocation or revocation letter without prior approval from CMS' Provider Enrollment & Oversight Group (PEOG).)

When drafting a revocation letter (which, except as described in section 15.27.2(B)(2) below, must be sent to PEOG via the enrollmentescalations@cms.hhs.gov mailbox for approval), the contractor shall

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

1. Revocation Reason 1 (42 CFR §424.535(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements in subpart P (of Part 424) or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

Noncompliance includes, but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider or supplier has failed to pay any user fees as assessed under 42 CFR Part 488.

Other situations in which §424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.

f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.

g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment

information. (This revocation reason will not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason §424.540(a)(3) in lieu thereof.)

h. The provider or supplier does not otherwise meet general enrollment requirements.

i. The provider or supplier has its provider or supplier agreement involuntarily terminated by the CMS regional office (RO) (as evidenced by a tie-in/tie-out notice, CMS-2007, or other notice from the RO/state).

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

**NOTE:** The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

2. Revocation Reason 2 (42 CFR §424.535(a)(2)) – Excluded/Debarred from Federal Program

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) Excluded from the Medicare, Medicaid, and any other federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

If an excluded party is found, the contractor shall notify its CMS PEOG Business Function Lead (PEOG BFL) immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate Zone Program Integrity Contractor. The COR will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

3. Revocation Reason 3 (42 CFR §424.535(a)(3)) – Felony Conviction

The provider, supplier, or any owner or managing employee of the provider or

supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR §1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. Offenses include, but are not limited in scope and severity to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

An enrollment bar issued pursuant to 42 CFR §424.535(c) does not preclude CMS or its contractors from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all criteria necessary to enroll in Medicare.

4. Revocation Reason 4 (42 CFR §424.535(a)(4)) – False or Misleading Information on Application

The provider or supplier certified as ‘‘true’’ misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)

5. Revocation Reason 5 (42 CFR §424.535(a)(5)) - On-Site Review/Other Reliable Evidence that Requirements Not Met

Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

(i) Is not operational to furnish Medicare-covered items or services; or
(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

6. Revocation Reason 6 (§424.535(a)(6)) - Hardship Exception Denial and Fee Not Paid

(i) (A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or

(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(ii) (A) Either of the following occurs:

(1) CMS is not able to deposit the full application amount into a government-owned account; or

(2) The funds are not able to be credited to the United States Treasury;

(B) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

7. Revocation Reason 7 (42 CFR §424.535(a)(7)) – Misuse of Billing Number

The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers that enter into a valid reassignment of benefits as specified in 42 CFR §424.80 or a change of ownership as outlined in 42 CFR §489.18.

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

Abuse of billing privileges includes either of the following:

(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is

said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined in §424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

(**NOTE**: With respect to (a)(8), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider or supplier has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; (3) accumulate all information needed to make such determinations; and (4) prepare and send all revocation letters.)

9. Revocation Reason 9 (42 CFR §424.535(a)(9)) – Failure to Report Changes

The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.

With respect to Revocation Reason 9:

- This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

- If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines –

through an on-site inspection under 42 CFR §424.535(a)(5)(ii) or via another verification process - that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking PEOG's approval to revoke).

10. Revocation Reason 10 (42 CFR §424.535(a)(10)) – Non-Compliance with Documentation Requirements

The provider or supplier did not comply with the documentation requirements specified in 42 CFR §424.516(f).

11. Revocation Reason 11 (42 CFR §424.535(a)(11)) - Home Health Agency (HHA) Capitalization

A home health agency (HHA) fails to furnish - within 30 days of a CMS or Medicare contractor request - supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR §489.28(a).

12. Revocation Reason 12 (42 CFR §424.535(a)(12)) – Medicaid Billing Privileges Revoked

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

(Medicare may not terminate a provider or supplier's Medicare billing privileges unless and until the provider or supplier has exhausted all applicable Medicaid appeal rights).

13. Revocation Reason 13 (42 CFR §424.535(a)(13)) - DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

14. Revocation Reason 14 (42 CFR §424.535(a)(14)) - CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements.

15. Refer to 15.27.3.c for an additional revocation reason specific to MDPP suppliers alone.

**B. Prior PEOG Approval**

1. Prior PEOG Approval Necessary

Except as described in section 15.27.2(B)(2) below, the contractor shall obtain approval of both the revocation and the revocation letter from PEOG via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the revocation letter. During its review, PEOG will also determine (1) the extent to which the revoked provider's or supplier's other locations are affected by the revocation, (2) the geographic application of the reenrollment bar, and (3) the effective date of the revocation. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior PEOG Approval Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- Situation (a), (c), (d), (e), (g), (h), or (i) under Revocation Reason 1 above

§424.535(a)(6) or (a)(11)

**C. Effective Date of Revocations**

Per 42 CFR §424.535(g), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. However, a revocation based on a: (1) Federal exclusion or debarment; (2) felony conviction as described in 42 CFR §424.535(a)(3); (3) license suspension or revocation; or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.
As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed (with prior PEOG approval) if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its revocation letter. It is up to the provider/supplier to furnish this data on its own volition.

- Has the discretion to determine whether sufficient "proof" exists.

**D. Re-enrollment Bar**

1. Background

As stated in 42 CFR §424.535(c), if a provider, supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. (Felony convictions, however, always entail a 3-year bar.) Per §424.535(c), the reenrollment bar does not apply if the revocation (1) is based on §424.535(a)(1), <u>and</u> (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.

The contractor shall update the Provider Enrollment, Chain and Ownership System (PECOS) to reflect that the individual is prohibited from participating in Medicare for the applicable 1, 2, or 3-year period.

**(NOTE:** Reenrollment bars apply <u>only</u> to revocations, not to denials. The contractor shall not impose a reenrollment bar following a denial of an application.)

2. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. <u>It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances, and it should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases</u>. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 3 years).

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license; 3 years if billing after loss of license; 3 years for violation of a Medicare policy (using certification statement)

- §424.535(a)(2) (Provider or Supplier Conduct) – 3 years

- §424.535(a)(3) (Felonies) – 3 years

- §424.535(a)(4) (False or Misleading Information) – 3 years

- §424.535(a)(5) (Onsite Review) – 2 years
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(7) (Misuse of Billing Number) – 3 years
- §424.535(a)(8) (Abuse of Billing) – 3 years
- §424.535(a)(9) (Failure to Report) - 1 year if licensure, practice location, revocation; 3 years if felony or exclusion
- §424.535(a)(10) (Failure to Provide CMS Access) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
- §424.535(a)(12) (Medicaid Termination) – 2 years
- §424.535(a)(13) (Prescribing Authority) – 2 years
- § 424.535(a)(14) (Improper Prescribing Practices) – 3 years

3. Applicability of Bar

In general, and unless stated otherwise above, any re-enrollment bar <u>at a minimum</u> applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include - but are not limited to – the following:

- John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under §424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.
- Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under §424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

- John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the

contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located, and John Smith is listed as a 75 percent owner.

**E. Submission of Claims for Services Furnished Before Revocation**

Per 42 CFR §424.535(h), a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the later of: (1) the effective date of the revocation, or (2) the date that the HHA's last payable episode ends.

Nothing in 42 CFR §424.535(h) impacts the requirements of § 424.44 regarding the timely filing of claims.

**F. Timeframe for Processing of Revocation Actions**

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider or supplier's billing privileges, the contractor shall complete all steps associated with the revocation no later than 5 business days from the date it received PEOG's approval/request. The contractor shall notify PEOG that it has completed all of the revocation steps no later than 3 business days after these steps have been completed.

**G. Provider Enrollment Appeals Process**

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

**H. Summary**

If the contractor determines that a provider's billing privileges should be revoked, it shall undertake the activities described in this section, which include, but are not limited to:

- Preparing a draft revocation letter;
- E-mailing the letter to PEOG via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;

- Receiving PEOG's determinations and abiding by PEOG's instructions regarding the case;

- If PEOG authorizes the revocation:

- Revoking the provider's billing privileges back to the appropriate date;
- Establishing the applicable reenrollment bar;
- Updating PECOS to show the length of the reenrollment bar;
- Assessing an overpayment, as applicable; and
- Affording appeal rights.

**I. Reporting Revocations/Terminations to the State Medicaid Agencies and Children's Health Program (CHIP)**

Section 6401(b)(2) of the Patient Protection and Affordable Health Care Act (i.e., the Affordable Care Act), enacted on March 23, 2010, requires that the Administrator of CMS establish a process for making available to each State Medicaid Plan or Child Health Plan the name, National Provider Identifier, and other identifying information for any provider of medical or other items or services or supplier who have their Medicare billing privileges revoked or denied.

To accomplish this task, CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. The contractor shall access this list on the 5th day of each month through the Share Point Ensemble site. The contractor shall review the monthly revoked and denied provider list for the names of Medicare providers revoked and denied in PECOS. The contractor shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier's revocation or denial.

The contractor shall update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. The contractor shall not make any other modifications to the format of this form or its contents. The following terms are the only authorized entries to be made on the report:

Appeal Submitted:
Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)
No - (definition: no appeal of any type has been submitted)

Appeal Type:
CAP
Reconsideration
ALJ
DAB

Appeal Status:

Under Review
Revocation Upheld
Revocation Overturned
Denial Upheld
Denial Overturned
CAP accepted
CAP denied
Reconsideration Accepted
Reconsideration Denied

If a contractor is reporting that no appeal has been submitted, the appeal type and status columns will be noted as N/A.

If an appeal action has been submitted to PEOG for certified providers or suppliers, contractors shall access the PEOG appeals log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to its designated PEBFL.

**J. Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers**

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- E-mail a copy of the revocation letter to the applicable RO's Division of Survey & Certification corporate mailbox. (The RO will notify the state of the revocation.)

- After determining the effective date of the revocation, end-date the entity's enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in the same manner as it would upon receipt of a tie-out notice from the RO.

Afford the appropriate appeal rights per section 25 of this chapter.
K. Overpayments Based Upon Revocations

In situations where a revocation is made with a prospective (i.e., 30 days from the date of CMS or the contractor's mailing of the revocation notification letter to the provider) effective date, the contractor's shall assess an overpayment back to a date when Medicare claims are determined to be ineligible for payment. This date may, but will not always, match the inactive date of the enrollment that is reflected in PECOS and MCS or FISS. The starting date upon which claims are not eligible for reimbursement is what the contractor's shall use to assess an

overpayment, not the date the enrollment is inactive according to PECOS and MCS or FISS.

The contractor shall initiate procedures to collect overpayment after the appeal filing timeframe has expired or within 10 days of the final appeal determination by the contractor.

- In accordance with 42 CFR §424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009.

## 15.27.5 – Rebuttal Process

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

### A. Background

Pursuant to 42 C.F.R. § 424.545(b), a provider or supplier whose Medicare billing privileges have been deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374. A rebuttal is an opportunity for the provider or supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per deactivation. Additional rebuttal requests shall be dismissed.

If an application is received for a deactivated provider or supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application in accordance with current processing instruction. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless the submitted application is required to reactivate the provider's or supplier's enrollment. If an application, received while a rebuttal submission is pending, is approved prior to the issuance of a rebuttal determination and results in the provider's or supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

Providers and suppliers may submit a rebuttal request for the following deactivation reasons, in accordance with 42 C.F.R. § 424.540(a):

(1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.

(2) The provider or supplier does not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).

(3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

**B. Notification Letters for Deactivations**

If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities identified in 42 C.F.R. § 424.540, the contractor shall deactivate the provider's or supplier's Medicare billing privileges unless another CMS direction is applicable. If a revocation authority is applicable, the contractor shall follow the current revocation instruction in 15.27.2, in lieu of deactivating the enrollment. If no revocation authority is applicable, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider's or supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via email if a valid email address is available. The contractor should also send via fax if a valid fax number is available. All notifications shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

## 15.27.5.1 – Rebuttal Submissions

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

**A. Requirements and Submission of Rebuttals**

The rebuttal submission:

1) Must be received by the contractor within 20 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, email, and/or fax;

2) Must specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement;

3) Should include all documentation and information the provider or supplier would like to be considered in reviewing the deactivation;

4) Must be submitted in the form of a letter that is signed and dated by the individual provider, supplier, the authorized or delegated official, or a legal representative, as defined in 42 C.F.R. § 498.10. If the legal representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier. This statement is sufficient to constitute notice. If the legal representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed and dated by the individual provider or supplier, the authorized or delegated official, or a legal representative.

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a develop request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15 calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission is not appropriately signed and no response is received to the development request (if applicable), untimely (as described above), does not specify the facts or issues with which the provider or supplier disagrees and the reasons for disagreement, or is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable model rebuttal dismissal letter. The contractor may make a good cause determination so as to accept any rebuttal that has been submitted beyond the 20 calendar day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider's or supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

**B. Time Calculations for Rebuttal Submissions**

The date of receipt of a deactivation notice is presumed to be 5 days after the date on the deactivation notice unless there is a showing that it was, in fact, received earlier or later.

Therefore, the rebuttal must be received within 20 calendar days from the date of the deactivation notice to be considered timely. If the 20$^{th}$ calendar day from the date on the deactivation notice falls on a weekend or federally recognized holiday, then the rebuttal shall be accepted as timely if received by the next business day.

Consider the following example:

> A deactivation notice is dated April 8, 2018. The provider or supplier is presumed to have received the deactivation notice on April 13, 2018. The provider or supplier submits a rebuttal that is received on April 28, 2018. The 20th calendar day from the date on the deactivation notice is April 28, 2018. However, since April 28, 2018 is a Saturday (weekend day), the rebuttal submission received on April 30, 2018 is considered timely because April 30, 2018 is the next business day following the 20th calendar day from the date on the deactivation notice.

It is the provider's or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

**C. Processing Rebuttal Submissions**

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar days of receipt of the accepted rebuttal request using the model rebuttal acknowledgment letter, including a rebuttal tracking number. The acknowledgement letter shall also be sent via email, if a valid email address is available. It is optional for the contractor to send the acknowledgement letter via fax, if a valid fax number is available.

The contractor shall process all accepted rebuttal submissions within 30 calendar days of the date of receipt. If while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued.

The contractor's review shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider or supplier shall be considered by the contractor in their review.

1) For deactivations under 42 C. F. R. § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the twelve month period preceding the date of deactivation, starting with the 1st day of the 1st month twelve months prior to the date of deactivation. If it is confirmed that billing occurred within twelve months, the contractor shall issue a favorable rebuttal determination. If it no billing occurred during the twelve month period prior to the date of

deactivation, the contractor shall issue an unfavorable rebuttal determination.

Consider the following example:

Dr. Awesome has been enrolled in the Medicare program since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2016. Dr. Awesome's enrollment is deactivated effective January 1, 2018. Dr. Awesome timely submits a rebuttal statement regarding the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is confirmed that Dr. Awesome had not submitted claims since January 2016. Therefore, an unfavorable determination would be appropriate in this scenario, as the deactivation was justified.

2) For deactivations under 42 C. F. R. § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within 90 calendar days of when the change occurred. If information was submitted properly and timely, the contractor shall approve the rebuttal request and reinstate the provider's or supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, as the deactivation was justified. In making this determination, the contractor shall consider, at minimum, the following.

    a. Whether the deactivation was implemented after 90 days of when the change of enrollment information occurred.
    b. Whether the letter notifying the provider or supplier of the deactivation was sent to the correct address as instructed in section 15.24.
    c. Whether the enrollment changes were received in an enrollment application that was processed to completion within 90 days of when the change of enrollment occurred.

Consider the following example:

Dr. Happy has reassigned his benefits to physician group Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on April 15, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal to the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received on February 28, 2018 that sought to update his practice location. However, this

application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 90 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 90 days of the change of enrollment information. Though an application was received within 90 days of the change of enrollment information, that application was not processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

3) For deactivations under 42 C. F. R. 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following.
    a. Whether the deactivation was implemented after 90 days of the revalidation request.
    b. Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 15.24.
    c. Whether a revalidation application was timely received that was processed to completion.

Consider the following example:

On January 1, 2018, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2018. The contractor receives a revalidation application from Dr. Great on March 1, 2018. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2018 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2018. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contactor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission shall be sent via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider or supplier's Medicare billing privileges within ten business days of the date the favorable determination is issued. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contactor issues a rebuttal determination unfavorable to the provider or supplier, the provider's or supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If additional information/documentation is needed prior to reinstating the provider or supplier (e.g. deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in their rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider or supplier to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

**D. Rebuttal Determination is Not Subject to Further Review**

Pursuant to the rebuttal regulation at 42 C.F.R. § 405.375(c), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Therefore, no additional appeal rights shall be included on any rebuttal determination letter.

## 15.27.5.2 – Rebuttal Model Letters

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

**A. Instruction**

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.

**B. Rebuttal Signature Development Model Letter**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 15, Section 15.27.5.1. [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice.

If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

## C. Rebuttal Further Information Required Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD]. [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**D. Rebuttal Moot Model Letter**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**E. Rebuttal Withdrawn Model Letter**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**F. Rebuttal Receipt Acknowledgement Model Letter**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).
**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**G. Final Rebuttal Decision Email Template**

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

Dear [Name of the person(s) who submitted the rebuttal]:
Please see the attached determination regarding your rebuttal.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**H. Rebuttal Dismissal Model Letters**

1. **Untimely**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 20 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

2. **Improper Signature**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name] [Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within 20 calendar days of the date of the deactivation letter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

### 3. No Rebuttal Rights

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name].

[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

### 4. More than One Submission

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 15 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]

[MAC Name]

**I. Rebuttal Not Actionable Model Letter (Moot)**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]
[MAC Name]

**J. Favorable Rebuttal Model Letter**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)(1-3)

**OTHER APPLICABLE AUTHORITIES:**

- 42 C.F.R. §
- Medicare Program Integrity Manual (MPIM) chapter 15.XX (If applicable).

**EXHIBITS:**

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

**BACKGROUND:**

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

**REBUTTAL ANALYSIS:**

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

**DECISION:**

(A short conclusory restatement.)

(**Example:** On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges is not justified based on the information available.

This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

**(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed**

**from the provider or supplier in this rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)**

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

**K. Unfavorable Rebuttal Model Letter**

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

**To:** [Email address provided by the person who submitted the rebuttal.]

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address](Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment

record, and any information received before this decision was rendered.

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)(1-3)

**OTHER APPLICABLE AUTHORITIES:**

- 42 C.F.R. §
- Medicare Program Integrity Manual chapter 15.XX (If applicable)

**EXHIBITS:**

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

**BACKGROUND:**

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the rebuttal.]

**REBUTTAL ANALYSIS:**

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

**DECISION:**

(A short conclusory restatement.)

(**Example**: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-3) is justified.)

This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

## 15.27.5.3 – Rebuttal Reporting Requirements

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

### A. Monthly

Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column should be left blank.

The response in the column labelled "Final Decision Result" should be one of the following:

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved.

- **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation

was not justified and the enrollment record has been placed back into an approved status.

- **Unfavorable (to provider/supplier):** MAC has determined that the deactivation was justified and the enrollment record remains deactivated.

- **Dismissed:** The appeal does not meet the rebuttal submission requirements. (Ex: incorrect signature, untimely, not rebuttable, etc.

- **Rescinded:** MAC has received instruction from CMS to rescind the deactivation and return the enrollment record to an approved status.

- **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its rebuttal.

The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month; the report shall cover the prior month's rebuttal submissions (e.g., the February report shall cover all January rebuttals). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

## 15.28 – Deceased Practitioners

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

### A. Reports of Death from the Social Security Administration (SSA)

Contractors, including the NSC MAC, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities described below.

### B. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners and/or Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

If the person is an owner, sole owner of a professional corporation or professional association, managing employee, director, officer, authorized official, etc., the contractor shall verify and document that the person is deceased using the process described in section (C)(1) below.

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the

provider's Medicare billing privileges in accordance with 42 CFR §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR §424.57(c)(2).)

The contractor need not, however, solicit a Form CMS-855 change request if the organization is enrolled with another contractor. Here, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

**C. Reports of Death from Third-Parties**

1. Verification

If a contractor, including DME MACs or the NSC MAC, receives a report of death from a third-party (state provider association, state medical society, academic medical institution, etc.), the contractor shall verify that the physician, non-physician practitioner or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits;

- Obtaining an obituary notice from the newspaper;

- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);

- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or

- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

2. Post-Confirmation Actions

Once the contractor verifies the death, it shall:

1. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.

2. Search PECOS to determine whether the individual is listed therein as an owner, sole owner of a professional corporation or professional association, managing employee, director, officer, partner, authorized official, or delegated official of another supplier.

3. If the person is not in PECOS, no further action with respect to that individual is needed.

4. If the supplier is indeed identified in PECOS as an owner, officer, etc., the contractor shall notify the organization with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with §424.57(c)(2).)

The contractor need not, however, ask for a Form CMS-855 change request if the organization is enrolled with another contractor. In this situation, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

The contractor shall place verification documentation in the provider or supplier file in accordance with section 15.7.3 of this chapter.

**D. Education & Outreach**

Contractors, including DME MACs and the NSC MAC, shall conduct outreach to state provider associations, state medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death of physicians and non-physician practitioners participating in the Medicare program.

**E. Trustees/Legal Representatives**

1. NPI - The trustee/legal representative of a deceased physician, non-physician practitioner or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.

2. Special Payment Address - In situations where a physician, non-physician practitioner or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the physician, non-physician practitioner or DMEPOS supplier's estate to change the physician, non-physician practitioner or DMEPOS supplier's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.

- Any evidence – within reason - verifying that the physician, non-physician practitioner or DMEPOS supplier is in fact deceased.

- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner or DMEPOS supplier's estate.

The policies in this section 15.28(E)(1) and (2) apply only to physicians, non-physician practitioners, sole owners of a professional corporation or professional association, and DMEPOS suppliers who operated their business as sole proprietors. It does not apply to situations in which the physician or non-physician practitioner reassigned his or her benefits to another entity.

**F. Proof of Life Documentation**

On rare occasions erroneous death information may be received through the DMF process that results in systematic enrollment deactivations in PECOS or records populated on the Deceased Associates reports in PECOS for MAC deactivation actions. In order for the providers/suppliers to reactivate their enrollments and have the date of death removed from their PECOS records, MACs shall request documentation that supports "proof of life" (for example, Retirement, Survivors, and Disability Insurance document issued by SSA). In the event a provider/supplier is unable to obtain such documentation, the MAC shall submit a request to their PEOG Business Function Lead (BFL) containing the provider/supplier's name, date of birth and SSN so that CMS can confirm proof of life with SSA.

## 15.29.11 – Revalidation Extension Requests

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

MACs shall only accept extension requests from a provider or supplier that was not given the full seven months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. MACs shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the MAC shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. MACs shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the

individual provider, Authorized/Delegated Official or contact person.

## Transmittals Issued for this Chapter

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---|---|---|---|---|
| R10239PI | 07/28/2020 | Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08 | 08/10/2020 | 11551 |
| R10182PI | 06/15/2020 | Update to Chapter 10 of Publication (Pub.) 100-08 - Model Letter Templates | 09/16/2020 | 11375 |
| R10146PI | 05/22/2020 | Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08- Rescinded and replaced by Transmittal 10239 | 07/24/2020 | 11551 |
| R10138PI | 05/15/2020 | Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment) | 06/16/2020 | 11546 |
| | 11/22/2019 | Additional Guidance on Private Contracting/Opting-out of Medicare and Entering Opt-out Affidavit Records in the Provider Enrollment, Chain and Ownership System (PECOS) | 12/24/2019 | 10939 |
| R904PI | 09/27/2019 | Provider Enrollment Rebuttal Process | 12/31/2019 | 10978 |
| R902PI | 09/27/2019 | Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08 | 10/28/2019 | 11425 |
| R898PI | 09/06/2019 | Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08, Program Integrity Manual, and to the CMS-855R Processing Guide | 10/07/2019 | 11371 |
| R896PI | 08/30/2019 | Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08 | 10/01/2019 | 11325 |
| R882PI | 05/24/2019 | Additional Processing Procedure for Adding a New Provider-Based Location | 06/25/2019 | 11246 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---|---|---|---|---|
| | | for Critical Access Hospitals (CAHs) | | |
| R865PI | 02/21/2019 | Update to Chapter 15 of Publication (Pub.) 100-08 | 03/12/2019 | 10954 |
| R862PI | 02/08/2019 | Update to Chapter 15 of Publication (Pub.) 100-08- Rescinded and replaced by Transmittal 865 | 03/12/2019 | 10954 |
| R824PI | 09/052018 | Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies | 10/01/2018 | 10845 |
| R822PI | 08/24/2018 | Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies- Rescinded and replaced by Transmittal 824 | 10/01/2018 | 10845 |
| R797PI | 06/01/2018 | Reviewing for Adverse Legal Actions (ALA) | 04/30/2018 | 10558 |
| R762PI | 04/30/2017 | Update to Chapter 15 of Pub. 100-08 | 01/29/2018 | 10386 |
| R782PI | 03/30/2018 | Update to Chapter 15 of Publication 100-08 - Medicare Enrollment Deactivation Policies | 04/30/2018 | 10443 |
| R784PI | 03/30/2018 | Reviewing for Adverse Legal Actions (ALA) | 04/30/2018 | 10558 |
| R773PI | 02/23/2018 | Form CMS-855O Processing Guide | 03/23/2018 | 10355 |
| R765PI | 01/08/2018 | Medicare Diabetes Prevention Program (MDPP) Enrollment Process | 01/19/2018 | 10356 |
| R734PI | 07/28/2017 | Update to Reporting Requirements | 06/27/2017 | 9924 |
| R719PI | 05/26/2017 | Update to Reporting Requirements | 06/27/2017 | 9924 |
| R718PI | 05/19/2017 | Reviewing for Adverse Legal Actions (ALA) | 06/20/2017 | 9879 |
| R717PI | 05/12/2017 | Update to Pub. 100-08, Chapter 15 | 05/15/2017 | 9953 |
| R715PI | 05/11/2017 | Update to Pub. 100-08, Chapter 15 | 06/13/2017 | 9953 |
| R711PI | 04/25/2017 | Update to Pub. 100-08, Chapter 15 | 05/15/2017 | 9953 |
| R710PI | 04/14/2017 | Update to Pub. 100-08, Chapter 15 | 05/15/2017 | 9953 |
| R689PI | 12/09/2016 | Clarification of Certification Statement Signature and Contact Person Requirements | 01/09/2017 | 9776 |

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|---|---|---|---|---|
| R688PI | 11/18/2016 | Update to Pub. 100-08, Chapter 15 | 07/26/2016 | 9635 |
| R685PI | 11/03/2016 | Incorporation of Cycle 2 Revalidation Policies | 09/06/2016 | 9628 |
| R684PI | 11/01/2016 | Incorporation of Cycle 2 Revalidation Policies – Rescinded and replaced by Transmittal 685 | 12/02/2016 | 9628 |
| R681PI | 10/27/2016 | Revision to Surety Bond Collection Procedures | 01/30/2017 | 9755 |
| R676PI | 09/16/2016 | Clarification of Certain Policies in Pub. 100-08, Chapter 15 Regarding the Processing of Form CMS-855R Applications | 12/19/2016 | 9552 |
| R666PI | 08/05/2016 | Incorporation of Cycle 2 Revalidation Policies - Rescinded and replaced by Transmittal 684 | 09/06/2016 | 9628 |
| R659PI | 06/24/2016 | Update to Pub. 100-08, Chapter 15 - Rescinded and replaced by Transmittal 688 | 07/26/2016 | 9635 |
| R636PI | 02/04/2016 | Update to Pub. 100-08, Chapter 15 | 03/04/2016 | 9390 |
| R626PI | 11/13/2015 | Update to Surety Bond Collection Requirements | 12/14/2015 | 9296 |
| R609PI | 08/14/2015 | Clarification Regarding the Processing of Certain Provider Enrollment-Related Transactions | 11/02/2015 | 9174 |
| R605PI | 07/31/2015 | Clarification Regarding the Processing of Certain Provider Enrollment-Related Transactions – Rescinded and replaced by Transmittal 609 | 11/02/2015 | 9174 |
| R592PI | 05/08/2015 | Update of Provider Enrollment Instructions in Chapter 15 of Pub. 100-08 | 06/08/2015 | 9139 |
| R591PI | 05/08/2015 | Revisions to Surety Bond Collection Policies | 06/08/2015 | 9123 |
| R590PI | 04/24/2015 | Update of CMS-855A, Physician-Owned Hospital Reporting Via the CMS-855POH and Indirect Payment Procedure Registration Via the CMS-855C in Chapter 15 of Pub. 100-08 | 05/25/2015 | 9120 |
| R587PI | 04/17/2015 | Clarification of Ordering and Certifying Documentation Maintenance Requirements | 07/20/2015 | 9112 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---|---|---|---|---|
| R582PI | 03/04/2015 | Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 05/28/2015 | 9065 |
| R581PI | 02/27/2015 | Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 – Rescinded and replaced by Transmittal 582 | 05/28/2015 | 9065 |
| R578PI | 02/25/2015 | Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 05/15/2015 | 9011 |
| R575PI | 02/13/2015 | Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 – Rescinded and replaced by Transmittal 578 | 05/15/2015 | 9011 |
| R561PI | 12/12/2014 | Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 04/18/2015 | 8901 |
| R556PI | 11/26/2014 | Revisions to Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 12/29/2014 | 8810 |
| R539PI | 08/29/2014 | Cardiac Rehabilitation Programs for Chronic Heart Failure – Rescinded and replaced with Transmittal 539 | 08/18/2014 | 8758 |
| R532PI | 08/01/2014 | Incorporation of Various Form CMS-855 Processing Activities into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 | 09/02/2014 | 8842 |
| R530PI | 07/18/2014 | Cardiac Rehabilitation Programs for Chronic Heart Failure – Rescinded and replaced with Transmittal 539 | 08/18/2014 | 8758 |
| R525PI | 06/27/2014 | Update to Form CMS-855 Application Processing Sections of CMS Pub. 100-08, Chapter 15 | 07/29/2014 | 8637 |
| R521PI | 06/13/2014 | Submission of Community Mental Health Center (CMHC) Certifications of Compliance with Section 485.918(b)(1) | 07/15/2014 | 8784 |
| R519PI | 05/30/2014 | Revision to CMS Publication 100-08, Chapter 15 | 07/31/2014 | 8512 |
| R517PI | 05/16/2014 | Update to Surety Bond Collection | 06/17/2014 | 8636 |

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|---|---|---|---|---|
| | | Procedures | | |
| R514PI | 05/02/2014 | Update to CMS Publication 100-08, Chapter 15 | 06/03/2014 | 8682 |
| R509PI | 03/27/2014 | Change in Provider Enrollment Timeliness Standards | 06/02/2014 | 8551 |
| R507PI | 02/28/2014 | Change in Provider Enrollment Timeliness Standards – Rescinded and replaced by Transmittal 509 | 05/29/2014 | 8551 |
| R503PI | 01/24/2014 | Inter-Jurisdictional Reassignments | 02/25/2014 | 8545 |
| R502PI | 01/17/2014 | Registration of Entities Using the Indirect Payment Procedure (IPP) | 01/06/14 | 8284 |
| R499PI | 12/27/2013 | Update to Chapter 15 of the Program Integrity Manual | 01/28/2014 | 8544 |
| R494PI | 12/06/2013 | Registration of Entities Using the Indirect Payment Procedure (IPP) | 01/06/14 | 8284 |
| R492PI | 12/06/2013 | Additional Updates to Chapter 15 of the Program Integrity Manual (PIM) | 01/07/2014 | 8393 |
| R490PI | 11/06/2013 | Reassignment to Part A Critical Access Hospitals Billing Under Method II (CAH II) | 01/06/2014 | 8387 |
| R483PI | 08/16/2013 | Reassignment to Part A Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) – Rescinded and replaced by Transmittal 490 | 01/06/2014 | 8387 |
| R479PI | 08/01/2013 | Enrollment Denials When an Existing or Delinquent Overpayment Exists | 10/07/2013 | 8039 |
| R478PI | 08/02/2013 | Registration of Entities Using the Indirect Payment Procedure (IPP) – Rescinded and replaced by Transmittal 494 | 01/06/2014 | 8284 |
| R474PI | 07/05/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) | 10/08/2013 | 8341 |
| R471PI | 06/11/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) | 05/28/2013 | 8222 |
| R470PI | 05/31/2013 | Revision to Surety Bond Collection Process | 07/01/2013 | 8283 |
| R469PI | 05/31/2013 | Enrollment Denials When an Existing or Delinquent Overpayment Exists – Rescinded and replaced by Transmittal | 10/07/2013 | 8039 |

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|---|---|---|---|---|
| | | 479 | | |
| R463PI | 05/17/2013 | Model Letter Revisions | 06/07/2013 | 8117 |
| R462PI | 05/16/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) | 03/18/2013 | 8155 |
| R461PI | 04/26/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 471 | 05/28/2013 | 8222 |
| R459PI | 04/12/2013 | Tax Identification Numbers of Foreign Owning and Managing Entities and Individuals | 05/13/2013 | 8258 |
| R457PI | 04/02/2013 | Model Letter Revisions – Rescinded and replaced by Transmittal 463 | 04/22/2013 | 8117 |
| R456PI | 03/22/2013 | Model Letter Revisions – Rescinded and replaced by Transmittal 457 | 04/22/2013 | 8117 |
| R450PI | 02/15/2013 | Update to Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 462 | 03/18/2013 | 8155 |
| R445PI | 12/14/2012 | Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM) | 01/01/2014 | 7864 |
| R440PI | 11/23/2012 | Revisions to Appeals Section of Chapter 15 of the Program Integrity Manual (PIM) | 12/24/2012 | 8110 |
| R437PI | 11/02/2012 | Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 445 | 02/01/2013 | 7864 |
| R435PI | 10/19/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part IX | 11/20/2012 | 8019 |
| R433PI | 09/07/2012 | Review of Debarment List and Processing of Tie-in Notices | 10/09/2012 | 8020 |
| R431PI | 08/31/2012 | Ordering and Certifying Documentation-Maintenance Requirements | 10/01/2012 | 7890 |
| R430PI | 09/28/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VIII | 10/29/2012 | 7889 |
| R424PI | 06/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VI | 06/19/2012 | 7827 |
| R423PI | 06/01/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VII | 07/02/2012 | 7839 |

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|---|---|---|---|---|
| R421PI | 05/18/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VI – Rescinded and replaced by Transmittal 424 | 06/19/2012 | 7827 |
| R416PI | 04/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part III | 02/27/2012 | 7698 |
| R415PI | 04/13/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part V | 05/14/2012 | 7797 |
| R414PI | 04/06/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part IV | 05/07/2012 | 7763 |
| R412PI | 03/30/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part II | 04/30/2012 | 7646 |
| R410PI | 03/02/2012 | Instructions for Processing Form CMS-855O Submissions | 06/04/2012 | 7723 |
| R408PI | 02/22/2012 | Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators | 02/03/2012 | 7363 |
| R407PI | 02/09/2012 | Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures(This CR Fully Rescinds and Replaces CR 7177) | 01/27/2012 | 7681 |
| R405PI | 01/26/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM) –Part III – Rescinded and replaced by Transmittal 416 | 02/27/2012 | 7698 |
| R404PI | 01/20/2012 | General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part I | 04/22/2012 | 7579 |
| R403PI | 01/20/2012 | Claims Against Surety Bonds for Suppliers of Durable Medicare Equipment, Prosthetics. Orthotics and Supplies (DMEPOS) | 02/21/2012 | 7167 |
| R402PI | 01/13/2012 | Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures(This CR Fully Rescinds and Replaces CR 7177) – Rescinded and replaced by Transmittal 407 | 01/27/2012 | 7681 |
| R400PI | 11/21/2011 | Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 408 | 02/03/2012 | 7363 |

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---|---|---|---|---|
| R394PI | 10/27/2011 | Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 400 | 02/03/2012 | 7363 |
| R392PI | 10/14/2011 | Update to Notifications Sent to State Medicaid Agencies and Child Health Plans of Medicare Terminations for Certified Providers and Suppliers and Medicare Revocations for Providers and Suppliers. This CR rescinds and fully replaces CR 7017, 7074 and 7334 | 11/15/2011 | 7532 |
| R388PI | 09/16/2011 | Additional Review Activities for Home Health Agencies (HHAs) | 12/17/2011 | 7525 |
| R387PI | 09/01/2011 | Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare Beneficiaries | 10/18/2010 | 7097 |
| R380PI | 08/03/2011 | Advanced Diagnostic Imaging Accreditation Enrollment Procedures | 07/05/2011 | 7177 |
| R374PI | 05/06/2011 | Update to Notifications Sent to State Medicaid Agencies and Child Health Plans of Medicare Terminations for Certified Providers and Suppliers and Medicare Revocations for Providers and Suppliers | 06/06/2011 | 7334 |
| R373PI | 04/07/2011 | Advanced Diagnostic Imaging Accreditation Enrollment Procedures – Rescinded and replaced by Transmittal 380 | 07/05/2011 | 7177 |
| R372PI | 03/25/2011 | Effective Date of Certified Provider or Supplier Agreement or Approval | 04/25/2011 | 7232 |
| R371PI | 03/23/2011 | Implementation of Provider Enrollment Provisions in CMS-6028-FC | 03/25/2011 | 7350 |
| R369PI | 03/11/2011 | Advanced Diagnostic Imaging Accreditation Enrollment Procedures – Rescinded and replaced by Transmittal 373 | 06/12/2011 | 7177 |
| R365PI | 01/28/2011 | Diabetes Self-Management Training (DSMT) | 04/29/2011 | 7236 |

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|---|---|---|---|---|
| R363PI | 01/14/2011 | Clarification for Part A Contractors Including Audit and Claims Intermediaries Notifying Each Other via E-mail Upon Processing of the Initial Enrollment Application, Change of Information, Voluntary Termination, or Any Other CMS-855 Transaction | 02/15/2011 | 7221 |
| R358PI | 10/29/2010 | Indian Health Service (IHS) Facilities and Tribal Provider's Use of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) | 11/29/2010 | 7174 |
| R357PI | 10/01/2010 | Durable Medical Equipment (DME MAC) and the National Supplier Clearinghouse (NSC MAC) Procedures for Third Party Notification of Deceased Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Supplier Associates | 10/04/2010 | 6714 |
| R356PI | 09/24/2010 | Manual Redesign | 10/26/2010 | 7083 |
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