Transmittals for Chapter 15

15.1 – Introduction to Provider Enrollment
   15.7.1.3 – Verification of Data/Processing Alternatives
   15.7.5.2 – Special Procedures for MDPP Suppliers
   15.7.6 – Special Processing Guidelines for Form CMS-855A, Form CMS-855B, and Form CMS-855I, and Form CMS-20134 Applications
   15.7.7.7 – Contractor Jurisdictional Issues

15.13 – Delinquent or Existing Overpayments
   15.14.2 – Contractor Communications
      15.21.7.1.1 – Model Letters for Claims Against Surety Bonds
   15.24.3 – Model Rejection Letter
   15.24.4 – Model Returned Application Letter

15.24.8 – Denial Letter Guidance
   15.24.8.1 – Model Denial Letter
   15.24.8.2 – Denial Example #1 – Discipline Not Eligible
   15.24.8.3 – Denial Example #2 – Criteria for Eligible Discipline Not Met
   15.24.8.4 – Denial Example #3 – Provider Standards Not Met
   15.24.8.5 – Denial Example #4 – Business Type Not Met
   15.25.1.1 – Corrective Action Plans (CAPs)
   15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers
   15.25.1.3 – Additional Appeal Levels
   15.25.2 – Appeals Involving Non-Certified Suppliers and Certified Suppliers
      15.25.2.1 – Corrective Action Plans (CAPs)
15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers
15.25.2.3 – Additional Appeal Levels

15.26.2 - Capitalization

15.27 – Deactivations and Revocations
   15.27.1.2 – Reactivations
   15.27.1.2.3 – Reactivations – Miscellaneous Policies

15.27.2 - Revocations

15.27.5 – Rebuttal Process
   15.27.5.1 – Rebuttal Submissions
   15.27.5.2 – Rebuttal Model Letters
   15.27.5.3 – Rebuttal Reporting Requirements

15.29.11 – Revalidation Extension Requests
15.1 – Introduction to Provider Enrollment

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.

15.7.1.3 – 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.

15.7.5.2 – 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.

15.7.7.7 – 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.

**15.10.2 - 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]

15.13 – 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
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).

15.14.2 – 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.”

15.21.7.1.1 – 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

15.24.3 – 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:
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)

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]


[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,
15.25.1.1 – Corrective Action Plans (CAPs)

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:

1. 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 who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination. 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

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)
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.
15.25.2.1 – Corrective Action Plans (CAPs)

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

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

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.

15.27 – Deactivations and Revocations

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.

15.27.1.2 – 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.)

15.27.1.2.3 – 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. 10383; Issued: 10-09-2020; Effective: 11-10-2020; Implementation: 11-10-2020)

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.


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 Unified Program Integrity Contractor. The COR will, in turn, contact the Office of Inspector General's office with the findings for further investigation.


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).

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).


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

(Medicare may not terminate a provider or supplier’s Medicare billing privileges unless and until the provider or supplier has exhausted all applicable Medicaid appeal rights).

13. Revocation Reason 13 (42 CFR §424.535(a)(13)) - DEA Certificate/State Prescribing Authority Suspension or Revocation

(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

14. Revocation Reason 14 (42 CFR §424.535(a)(14)) - CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements.

15. Refer to 15.27.3.c for an additional revocation reason specific to MDPP suppliers alone.

B. Prior PEOG Approval

1. Prior PEOG Approval Necessary

Except as described in section 15.27.2(B)(2) below, the contractor shall obtain approval of both the revocation and the revocation letter from PEOG via the MACRevocationRequests@cms.hhs.gov mailbox prior to sending the revocation letter. During its review, PEOG will also determine (1) the extent to which the revoked provider’s or supplier’s other locations are affected by the revocation, (2)
the geographic application of the reenrollment bar, and (3) the effective date of the revocation. PEOG will notify the contractor of its determinations and instruct the contractor as to how to proceed.

2. Prior PEOG Approval Unnecessary

The contractor need not obtain prior PEOG approval of the revocation and the revocation letter if the revocation involves any of the following situations:

- Situation (a), (c), (d), (e), (g), (h), or (i) under Revocation Reason 1 above §424.535(a)(6) or (a)(11)

C. Effective Date of Revocations

Per 42 CFR §424.535(g), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. However, a revocation based on a: (1) Federal exclusion or debarment; (2) felony conviction as described in 42 CFR §424.535(a)(3); (3) license suspension or revocation; or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational. As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed (with prior PEOG approval) if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its revocation letter. It is up to the provider/supplier to furnish this data on its own volition.

- Has the discretion to determine whether sufficient “proof” exists.

D. Re-enrollment Bar

1. Background

As stated in 42 CFR §424.535(c), if a provider, supplier, owner, or managing employee has their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. (Felony convictions, however, always entail a 3-year bar.) Per §424.535(c), the reenrollment bar does not
apply if the revocation (1) is based on §424.535(a)(1), and (2) stems from a provider or supplier’s failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar will be applied.

The contractor shall update the Provider Enrollment, Chain and Ownership System (PECOS) to reflect that the individual is prohibited from participating in Medicare for the applicable 1, 2, or 3-year period.

(NOTE: Reenrollment bars apply only to revocations, not to denials. The contractor shall not impose a reenrollment bar following a denial of an application.)

2. Establishment of Length

The following serves merely as general, non-binding guidance regarding the establishment of the length of reenrollment bars. It is crucial to note that every situation must and will be judged on its own merits, facts, and circumstances, and it should not be assumed that a particular timeframe will always be applied to a specific revocation reason in all cases. CMS retains the discretion to apply a reenrollment bar period that is different from that indicated below (though which in no case will be greater than 3 years):

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license; 3 years if billing after loss of license; 3 years for violation of a Medicare policy (using certification statement)
- §424.535(a)(2) (Provider or Supplier Conduct) – 3 years
- §424.535(a)(3) (Felonies) – 3 years
- §424.535(a)(4) (False or Misleading Information) – 3 years
- §424.535(a)(5) (Onsite Review) – 2 years
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(7) (Misuse of Billing Number) – 3 years
- §424.535(a)(8) (Abuse of Billing) – 3 years
- §424.535(a)(9) (Failure to Report) -1 year if licensure, practice location, revocation; 3 years if felony or exclusion
- §424.535(a)(10) (Failure to Provide CMS Access) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
• §424.535(a)(12) (Medicaid Termination) – 2 years

• §424.535(a)(13) (Prescribing Authority) – 2 years

• § 424.535(a)(14) (Improper Prescribing Practices) – 3 years

3. Applicability of Bar

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider’s PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include -but are not limited to – the following:

• John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under §424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.

• Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under §424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

• John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ’s lone location was at 1 Jones Street. XYZ’s billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located, and John Smith is listed as a 75 percent owner.

E. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(h), a revoked provider or supplier (other than a home health agency (HHA)) must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter. A revoked HHA must submit all claims for items and services within 60 days after the later of: (1) the effective date of the revocation, or (2) the date that the HHA’s last payable episode ends.

Nothing in 42 CFR §424.535(h) impacts the requirements of § 424.44 regarding the
timely filing of claims.

F. Timeframe for Processing of Revocation Actions

If the contractor receives approval from PEOG (or receives an unrelated request from PEOG) to revoke a provider or supplier’s billing privileges, the contractor shall complete all steps associated with the revocation no later than 5 business days from the date it received PEOG’s approval/request. The contractor shall notify PEOG that it has completed all of the revocation steps no later than 3 business days after these steps have been completed.

G. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

H. Summary

If the contractor determines that a provider’s billing privileges should be revoked, it shall undertake the activities described in this section, which include, but are not limited to:

- Preparing a draft revocation letter;

- E-mailing the letter to PEOG via the ProviderEnrollmentRevocations@cms.hhs.gov mailbox with additional pertinent information regarding the basis for revocation;

- Receiving PEOG’s determinations and abiding by PEOG’s instructions regarding the case;

- If PEOG authorizes the revocation:
  - Revoking the provider’s billing privileges back to the appropriate date;
  - Establishing the applicable reenrollment bar;
  - Updating PECOS to show the length of the reenrollment bar;
  - Assessing an overpayment, as applicable; and
  - Affording appeal rights.

I. Reporting Revocations/Terminations to the State Medicaid Agencies and Children’s Health Program (CHIP)
Section 6401(b)(2) of the Patient Protection and Affordable Health Care Act (i.e., the Affordable Care Act), enacted on March 23, 2010, requires that the Administrator of CMS establish a process for making available to each State Medicaid Plan or Child Health Plan the name, National Provider Identifier, and other identifying information for any provider of medical or other items or services or supplier who have their Medicare billing privileges revoked or denied.

To accomplish this task, CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. The contractor shall access this list on the 5th day of each month through the Share Point Ensemble site. The contractor shall review the monthly revoked and denied provider list for the names of Medicare providers revoked and denied in PECOS. The contractor shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier’s revocation or denial.

The contractor shall update the last three columns on the tab named “Filtered Revocations” of the spreadsheet for every provider/supplier revocation or denial action taken. The contractor shall not make any other modifications to the format of this form or its contents. The following terms are the only authorized entries to be made on the report:

**Appeal Submitted:**

- Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)
- No - (definition: no appeal of any type has been submitted)

**Appeal Type:**

- CAP
- Reconsideration
- ALJ
- DAB

**Appeal Status:**

- Under Review
- Revocation Upheld
- Revocation Overturned
- Denial Upheld
- Denial Overturned
- CAP accepted
- CAP denied
- Reconsideration Accepted
- Reconsideration Denied

If a contractor is reporting that no appeal has been submitted, the appeal type and
status columns will be noted as N/A.

If an appeal action has been submitted to PEOG for certified providers or suppliers, contractors shall access the PEOG appeals log via theShare 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 contractors 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 20th calendar day from the date on the deactivation notice falls on a weekend or federally recognized holiday, then the rebuttal shall be accepted as timely if received by the next business day. Consider the following example:

A deactivation notice is dated April 8, 2018. The provider or supplier is presumed to have received the deactivation notice on April 13, 2018. The provider or supplier submits a rebuttal that is received on April 28, 2018. The 20th calendar day from the date on the deactivation notice is April 28, 2018. However, since April 28, 2018 is a Saturday (weekend day), the rebuttal submission received on April 30, 2018 is considered timely because April 30, 2018 is the next business day following the 20th calendar day from the date on the deactivation notice.

It is the provider’s or supplier’s responsibility to timely update its enrollment record to reflect any changes to the provider’s or supplier’s enrollment information including, but not limited to its correspondence address. Failure to timely update a
correspondence address or other addresses included in its Medicare enrollment record does not constitute an “in fact” showing that the deactivation notice was received after the presumed receipt date (as described above).

C. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar days of receipt of the accepted rebuttal request using the model rebuttal acknowledgment letter, including a rebuttal tracking number. The acknowledgement letter shall also be sent via email, if a valid email address is available. It is optional for the contractor to send the acknowledgement letter via fax, if a valid fax number is available.

The contractor shall process all accepted rebuttal submissions within 30 calendar days of the date of receipt. If while reviewing the rebuttal submission, the provider or supplier wishes to withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued.

The contractor’s review shall only consist of whether the provider or supplier met the enrollment requirements and if billing privileges were deactivated appropriately. All materials received by the provider or supplier shall be considered by the contractor in their review.

1) For deactivations under 42 C. F. R. § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the twelve month period preceding the date of deactivation, starting with the 1st day of the 1st month twelve months prior to the date of deactivation. If it is confirmed that billing occurred within twelve months, the contractor shall issue a favorable rebuttal determination. If 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 contractor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission shall be sent via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider or supplier, it shall make the necessary modification(s) to the provider or supplier’s Medicare billing privileges within ten business days of the date the favorable determination is issued. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contractor issues a rebuttal determination unfavorable to the provider or supplier, the provider’s or supplier’s Medicare billing privileges shall
remain deactivated until a reactivation application is received and processed to completion.

If additional information/documentation is needed prior to reinstating the provider or supplier (e.g. deactivation due to non-response to revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in their rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider or supplier to again request the additional information/documentation within 10 calendar days of not receiving a response. If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

D. Rebuttal Determination is Not Subject to Further Review

Pursuant to the rebuttal regulation at 42 C.F.R. § 405.375(c), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Therefore, no additional appeal rights shall be included on any rebuttal determination letter.

15.27.5.2 – Rebuttal Model Letters
(Rev. 904, Issued: 09-27-19, Effective: 12-31-19; Implementation: 12-31-19)

A. Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.

B. Rebuttal Signature Development Model Letter

(To be sent by hard-copy mail and email if email address is provided. Optional to send via fax if a valid fax number is available).

To: [Email address provided by the person who submitted the rebuttal.]

Subject: Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name]

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [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)
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].
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,
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)
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)
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)
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: [XXXXXXXXXXX]  
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.
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

<table>
<thead>
<tr>
<th>Rev #</th>
<th>Issue Date</th>
<th>Subject</th>
<th>Impl Date</th>
<th>CR#</th>
</tr>
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<tbody>
<tr>
<td>R10723PI</td>
<td>04/08/2021</td>
<td>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</td>
<td>08/10/2020</td>
<td>11551</td>
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<tr>
<td>R10611PI</td>
<td>03/19/2021</td>
<td>Completion of Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08</td>
<td>11/19/2020</td>
<td>11917</td>
</tr>
<tr>
<td>R10383PI</td>
<td>10/09/2020</td>
<td>Updates to Chapters 4, 5, 8, 15, and Exhibits of Publication (Pub.) 100-08</td>
<td>11/10/2020</td>
<td>11999</td>
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<td>R10355PI</td>
<td>09/18/2020</td>
<td>Completion of Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08- Rescinded and replaced by transmittal 10611</td>
<td>11/19/2020</td>
<td>11917</td>
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<td>R10353PI</td>
<td>09/11/2020</td>
<td>Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10 of Pub. 100-08, Modification of the Timeliness Standards</td>
<td>02/01/2021</td>
<td>11865</td>
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<td>R10239PI</td>
<td>07/28/2020</td>
<td>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 10723</td>
<td>08/10/2020</td>
<td>11551</td>
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<td>R10182PI</td>
<td>06/15/2020</td>
<td>Update to Chapter 10 of Publication (Pub.) 100-08 - Model Letter Templates</td>
<td>09/16/2020</td>
<td>11375</td>
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<td>Subject</td>
<td>Impl Date</td>
<td>CR#</td>
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<td>R10146PI</td>
<td>05/22/2020</td>
<td>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</td>
<td>07/24/2020</td>
<td>11551</td>
</tr>
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<td>R10138PI</td>
<td>05/15/2020</td>
<td>Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment)</td>
<td>06/16/2020</td>
<td>11546</td>
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<tr>
<td>R904PI</td>
<td>09/27/2019</td>
<td>Provider Enrollment Rebuttal Process</td>
<td>12/31/2019</td>
<td>10978</td>
</tr>
<tr>
<td>R902PI</td>
<td>09/27/2019</td>
<td>Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08</td>
<td>10/28/2019</td>
<td>11425</td>
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<td>R898PI</td>
<td>09/06/2019</td>
<td>Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08, Program Integrity Manual, and to the CMS-855R Processing Guide</td>
<td>10/07/2019</td>
<td>11371</td>
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<td>R896PI</td>
<td>08/30/2019</td>
<td>Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08</td>
<td>10/01/2019</td>
<td>11325</td>
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<td>R882PI</td>
<td>05/24/2019</td>
<td>Additional Processing Procedure for Adding a New Provider-Based Location for Critical Access Hospitals (CAHs)</td>
<td>06/25/2019</td>
<td>11246</td>
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<td>R865PI</td>
<td>02/21/2019</td>
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<td>03/12/2019</td>
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<td>Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 400</td>
<td>02/03/2012</td>
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<td>R392PI</td>
<td>10/14/2011</td>
<td>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</td>
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<td>09/16/2011</td>
<td>Suppliers. This CR rescinds and fully replaces CR 7017, 7074 and 7334</td>
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<td>Additional Review Activities for Home Health Agencies (HHAs)</td>
<td>10/18/2010</td>
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<td>R374PI</td>
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<td>Advanced Diagnostic Imaging Accreditation Enrollment Procedures</td>
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<td>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</td>
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<td>Effective Date of Certified Provider or Supplier Agreement or Approval</td>
<td>04/25/2011</td>
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<td>06/12/2011</td>
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<td>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</td>
<td>02/15/2011</td>
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<td>R358PI</td>
<td>10/29/2010</td>
<td>Indian Health Service (IHS) Facilities and Tribal Provider’s Use of Internet-based Provider Enrollment, Chain and</td>
<td>11/29/2010</td>
<td>7174</td>
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<td>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</td>
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<td>Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare Beneficiaries</td>
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<td>Notification to State Medicaid Agencies and Child Health Plans of Medicare Revocation</td>
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Back to top of Chapter