

# Medicare Program Integrity Manual

## Chapter 15 - Medicare Enrollment

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## **15.1 – Introduction to Provider Enrollment**

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

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

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

### **15.1.2 – Medicare Enrollment Application (Form CMS-855)**

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

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

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- Paper enrollment application process (e.g., Form CMS-855I).

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

The five enrollment applications are distinguished as follows:

- CMS-855I - This application should be completed by physicians and non-physician practitioners who render Medicare Part B services to beneficiaries. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity.)
- CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The individual must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.
- CMS-855B - This application should be completed by supplier organizations (e.g., ambulance companies) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

- CMS-855A - This application should be completed by institutional providers (e.g., hospitals) that will furnish Medicare Part A services to beneficiaries.
- CMS-855S – This application should be completed by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The National Supplier Clearinghouse (NSC) is responsible for processing this type of enrollment application.
- CMS – 20134– This application should be completed by any supplier organizations that will furnish and bill Medicare Part B for the Medicare Diabetes Prevention Program services furnished to Medicare beneficiaries.

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

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

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

### **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

PEOG approval to do so.

Consider the following examples:

Example #1: Hospital X has a \$200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new Form CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a \$50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the \$50,000 overpayment was attached to him as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the \$50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a \$20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a Form CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the \$20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

**NOTE:** The contractors shall also observe the following:

- In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.
- The instructions in this section 15.8.4 apply only to (1) initial enrollments, and (2) new owners in a change of ownership.

The term "owner" under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)

- If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 15.8.4, the contractor shall not deny the application based on 42 CFR §424.530(a)(6).

### **15.14.2 – 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:



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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]  
[Title]  
[Company]

**15.24.4 – Model Returned Application Letter**  
**(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

[month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

[List all reasons for return]

If you would like to resubmit an application, you must complete a new Medicare enrollment application(s). Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.
2. Paper application process: Download and complete the Medicare

enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

Please return the completed application(s) to:

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]  
[Title]  
[Company]

**15.24.5 – Model Revalidation Letter**  
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

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**REVALIDATION**

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[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

**What record needs revalidating by [Due date, as Month dd yyyy]**

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at [go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation).

### What you need to do

**Revalidate your Medicare enrollment record**, through [PECOS.cms.hhs.gov](http://PECOS.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- **Online:** [PECOS](http://PECOS) is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of form [CMS-855 or Form CMS-20134] for your situation at [cms.gov](http://cms.gov). We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search [cms.gov](http://cms.gov) for "[CR 7350](#)" or "[Fee Matrix](#)".

### If you need help

Visit [go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation)

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

### 15.24.5.1 – Model Revalidation Letter – CHOW Scenario Only (Rev. 578, Issued: 02-25-15, Effective: 05-15-15, Implementation: 05-15-15)

[Month Day & Year]

PROVIDER/SUPPLIER NAME  
ADDRESS 1, ADDRESS 2  
CITY STATE ZIP CODE

NPI:  
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION  
REQUEST

**IMMEDIATELY SUBMIT AN UPDATED  
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO  
VALIDATE YOUR ENROLLMENT INFORMATION**

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the CMS Regional Office (RO) and the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the CMS RO and the State Agency for their final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at <https://www.cms.gov/MedicareProviderSupEnroll/>. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if the current version or later, approved by the Office of Management and Budget (OMB) on 09/2013, is not on file with Medicare. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician

practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, changes of ownership or control, including changes in authorized official(s) must be reported within 30 days; all other changes to enrollment information must be made within 90 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,  
[Your Name]  
[Title]

**15.24.5.2 – Model Large Group Revalidation Notification Letter  
(Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)**

[Month Day & Year]

PROVIDER/SUPPLIER GROUP NAME  
ADDRESS 1, ADDRESS 2  
CITY STATE ZIP CODE

NPI:  
PTAN:

Dear Provider/Supplier Group Name:

**THIS IS NOT A PROVIDER ENROLLMENT REVALIDATION REQUEST**

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. They will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician and/or non-physician practitioner to revalidate all their Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]  
[Title]

### **15.24.5.3 – Model Revalidation Pend Letter**

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

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## **PAYMENT HOLD**

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[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

### **What record needs revalidating**

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at [go.cms.gov/MedicareRevalidation](https://go.cms.gov/MedicareRevalidation).

### **How to resume your payments**

**Revalidate your Medicare enrollment record**, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- **Online:** [PECOS](https://pecos.cms.hhs.gov) is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at [cms.gov](https://cms.gov). We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

### **If you need help**

Visit [go.cms.gov/MedicareRevalidation](https://go.cms.gov/MedicareRevalidation)

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

### **15.24.5.4 – Model Revalidation Deactivation Letter**

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

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

STOPPING BILLING PRIVILEGES

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for the NSC], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments:

[Legal Business Name] | [dba Name] |

<Repeat for other reassignments>

CMS lists the records that need revalidating at

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

**REBUTTAL RIGHTS:**

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.



The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at [cms.gov](https://cms.gov). We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help

Visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name] [Title] [Company]

### **15.24.5.5 – Model Revalidation Past-Due Group Member Letter (Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

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## **REVALIDATION | Past-Due Group Member**

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[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

### **What record needs revalidating**

[Name] | NPI [NPI] | PTAN [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at [go.cms.gov/MedicareRevalidation](https://www.cms.gov/MedicareRevalidation).

### **What your group member needs to do**

**Revalidate their Medicare enrollment record**, through [PECOS.cms.hhs.gov](https://www.cms.gov/PECOS), or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

### **If your group member needs help**

Visit [go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation)

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

[Name], [Title]

### **15.24.5.6 – Model Deactivation Letter due to Inactive Provider/Supplier Letter**

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

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

#### **STOPPING BILLING PRIVILEGES**

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

**We have stopped your Medicare billing privileges** on [deactivation date], due to inactivity. We will not pay any claims after this date.

#### **What record has been deactivated**

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments:

[Legal Business Name] | [dba Name]  
<Repeat for other reassignments>

### **REBUTTAL RIGHTS:**

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal request.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

### **How to recover your billing privileges**

**Reactivate your Medicare enrollment record**, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [form CMS-855 or Form CMS-20134].

- **Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.
- **Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at [cms.gov](https://cms.gov). We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

## If you need help

Visit [go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation)

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,  
[Name], [Title]

### **15.24.5.7 – Model Return Revalidation Letter (Rev. 865; Issued: 02-21-19; Effective: 03-12-19; Implementation: 03-12-19)**

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## **RETURN REVALIDATION**

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[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
  - An unsolicited revalidation is one that is received more than seven months prior to the provider/suppliers due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
  - To find the provider/suppliers revalidation due date, please go to <http://go.cms.gov/MedicareRevalidation>.
  - If you are not due for revalidation in the current six month period, you will find that your due date is listed as “TBD” (or To Be Determined). This means that you do not yet have a due date for revalidation within the current six month period. This list will be updated monthly.
- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark ‘change’ in section 1 of the [form CMS-855 or Form CMS-20134].

- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS).

Go to: <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>. DMEPOS

suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

### **If you need help**

Visit <http://go.cms.gov/MedicareRevalidation>, or

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name], [Title]

## **15.24.8 – Denial Letter Guidance**

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

- The contractor must submit one or more of 10 Primary Denial Citations as found in x.x.x into the appropriate section on the Model Denial Letter. Only the CFR citation and a short heading shall be cited for the primary denial reason.
- The contractor may submit a Specific Denial Reason, as appropriate. The Specific Denial Reason should state sufficient details so it is clear as to why the provider or supplier is being denied.
- Specific Denial Reasons may contain one or more of the following items:
  - A specific regulatory (CFR) citation.
  - Dates (of actions, suspensions, convictions, receipt of documents, etc.)
  - Pertinent details of action(s)
- National Supplier Clearinghouse (NSC) only language. All denial letters for the NSC shall replace the 1<sup>st</sup> paragraph of the model denial letter with the following text:

**Your application to enroll in Medicare is denied. After reviewing your submitted application document(s), it was determined that per 42 CFR §405.800, 42 CFR §424.57, and 42 CFR §498.22, that you do not meet the conditions of enrollment or meet the requirements to qualify as a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider or supplier for the following reason(s):**

Exclusions and sanctions – the following two sentences should be REMOVED for all denial letters that DO NOT involve an exclusion or sanction action:

**You may not appeal through this process the merits of any exclusion by another federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the federal agency that took the action.**

For IDTF, DMEPOS, and MDPP providers and suppliers, each regulatory citation needs to be listed along with the specific regulatory language. For IDTF, the standards are found in 42 CFR §410.33(g) 1 through 17. For DMEPOS providers and suppliers, the standards are found in 42 CFR §424.57(c) 1 through 30. For MDPP suppliers, the standards are found in 42 CFR §424.205(d).

### **15.24.8.1 – Model Denial Letter**

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

[month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

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

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

The reconsideration request should be sent to:

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,



[Name]  
[Title]  
[Company]

**15.24.8.2 – Denial Example #1 – Discipline Not Eligible**  
**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 5, 2012

Xantippe Jones, LMFT  
7824 Freudian Way  
Yakima, WA 94054

Reference # (Contractor Control Number or NPI)

Dear Mr. Jones:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) – Not in Compliance with Medicare Requirements

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

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a

hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon  
Provider Enrollment Analyst  
Medicare Administrative Contractor, Inc.

### **15.24.8.3 – Denial Example #2 – Criteria for Eligible Discipline Not Met**

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 7, 2012

Marjorie Gosling, NP  
6578 Billings Avenue  
Calgary, MI 42897

Reference # (Contractor Control Number or NPI)

Dear Ms. Gosling:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Per 42 CFR §410.75(b)(1)(i), the provider or supplier is not certified by a recognized national certifying body that has established standards for nurse

practitioners.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Muffy McDowell  
Provider Enrollment Analyst

Medicare Administrative Contractor, Inc.

**15.24.8.4 – Denial Example #3 – Provider Standards Not Met  
(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 1, 2012

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

Reference # (Contractor Control Number or NPI)

Dear IDTF Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(5) - On-site Review - Requirements Not Met

Specifically, the following standards were not met:

42 CFR §410.33(g) 4 - Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

42 CFR §410.33(g) 9 - Openly post these [IDTF] standards for review by patients and the public

42 CFR §410.33(g) 11 - Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

42 CFR §410.33(g) 12 - Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective

action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz  
Provider Enrollment Analyst  
Medicare Administrative Contractor, Inc.

**15.24.8.5 – Denial Example #4 – Business Type Not Met  
(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

June 5, 2012

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

Reference # (Contractor Control Number or NPI)

Dear Mr. Bain:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

42 CFR §410.62(c)(ii) states that speech language pathologists in private practice must be engaged in one of the following practice types if allowed by State and local law: (A) An unincorporated solo practice; (B) An unincorporated partnership or unincorporated group practice; (C) An employee in an unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice; (D) An employee of a physician group (includes certain Non-Physician Practitioners [NPPs], as appropriate); or (E) An employee of a group that is not a professional corporation.

Your current private practice status is an incorporated solo practice; therefore, you do not qualify as a Medicare provider or supplier.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state

the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz  
Applications Analyst  
Medicare Administrative Contractor, Inc.

### **15.24.8.6 – Denial Example #5 – Existing or Delinquent Overpayments**

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

[Date]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your application to enroll in Medicare is denied for the following reason(s):

Denial Reason 6: (42 CFR §424.530(a)(6))

**The current owner (as defined in § 424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.**

Dates: (enter date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment of payments are currently being offset; Whether the overpayment is currently being appealed; the reason for the overpayment)

If you believe that you are able to correct the deficiencies and establish your eligibility in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services  
Center for Program Integrity  
Provider Enrollment & Oversight Group  
7500 Security Boulevard  
Mailstop Code (AR-18-50)  
Baltimore, MD 21244

If you believe that this determination is not correct, you may request a reconsideration before a hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §489.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:



Centers for Medicare & Medicaid Services  
Center for Program Integrity  
Provider Enrollment & Oversight Group  
7500 Security Boulevard  
Mailstop Code (AR-18-50)  
Baltimore, MD 21244

If you have any questions, please contact our office at (phone number) between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]  
[Title]  
[Company]

**15.24.8.7 – Denial Example #6 – MDPP Supplier Standards Not Met – Ineligible Coach**  
(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)

April 1, 2018

MDPP Services, Inc.  
2498 Prevention Way  
Koloa, Hawaii 96756

Reference # (Contractor Control Number or NPI)

Dear MDPP Services, Inc.:

Your application to enroll in Medicare is denied for the following reason(s):

42 CFR §424.530(a)(1) - Not in Compliance with Medicare Requirements

Specifically, the following standards were not met:

42 CFR §424.205(d)(3) - The MDPP supplier must not include on the roster of coaches nor permit MDPP services to be furnished by any individual coach who meets any of ineligibility criteria.

42 CFR §424.205(e)(v)(a) specifies that an individual with a state or federal felony conviction in the previous 10 years of any crime against persons, such as murder, rape, assault, and other similar crimes, would not meet the eligibility criteria to be an MDPP coach.

The following coach included on Section 7 of your Form CMS-20134 or its electronic equivalent meets this ineligibility criteria:

John B. Doe | DOB: June 19, 1991 | NPI: 1234567

Please see attached documentation of the felony conviction.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements and no longer have an ineligible coach on your roster. The CAP request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Peaches Barkowicz  
Provider Enrollment Analyst  
Medicare Administrative Contractor, Inc.

**15.24.9 – Revocation Letter Guidance**  
**(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)**

The contractor:

- Shall submit one or more of the Primary Revocation Reasons as found in section 15.27.2 or the MDPP specific Revocation Reason outlined in 15.27.3.c into the appropriate section of the Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason;
- Shall include sufficient details to support the reason for the provider or supplier's revocation;
- Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;
- Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.

**15.24.9.1 – Model Revocation Letter for Part B Suppliers and Certified Providers and Suppliers**  
**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

[Month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your Medicare privileges are being revoked effective [Date of revocation] for the following reasons:

xx CFR §xxx.(x) [heading]

[Specific reason]

xx CFR §xxx.(x) [heading]

[Specific reason]

(For certified providers and certified suppliers only: Pursuant to 42 CFR §424.535(b), this action will also terminate your corresponding (provider or supplier) agreement.)

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, and if this revocation is based in whole or in part on §424.535(a)(1), you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. (Per 42 CFR §405.809, a CAP cannot be accepted for revocations based exclusively on reasons other than §424.535(a)(1). If the revocation is for multiple reasons of which one is §424.535(a)(1), the CAP will only be reviewed with respect to the §424.535(a)(1) basis for revocation.) The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed and dated by the authorized or delegated official within the entity. CAP requests should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for reviewing the CAP.

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

or

[Centers for Medicare & Medicaid Services]  
[Provider Enrollment & Oversight Group]  
[7500 Security Blvd.]  
[Mailstop: AR-18-50]  
[Baltimore, MD 21244-1850])

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. However, if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process; you will not have another opportunity to do so unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e).

The reconsideration must be signed and dated by the authorized or delegated

official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

The reconsideration request should be sent to:

(Insert correct address based on whether the MAC or CMS is responsible for handling the reconsideration.

[Name of MAC]	or	[Centers for Medicare & Medicaid Services]
[Address]		[Provider Enrollment & Oversight Group]
[City], ST [Zip]		[7500 Security Blvd.]
		[Mailstop: AR-18-50]
		[Baltimore, MD 21244-1850])

Pursuant to 42 CFR §424.535(c), [Contractor name] is establishing a re-enrollment bar for a period of [Insert amount of time] that shall begin 30 days after the postmark date of this letter. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]  
[Title]  
[Company]

**15.24.9.2 – Model Revocation Letter for National Supplier Clearinghouse (NSC)  
(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

[month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

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

Certified mail number: [number]  
Returned receipt requested

Dear [Provider/Supplier Name]:

The purpose of this letter is to inform you that pursuant to 42 CFR §§ 405.800, 424.57(x), 424.535(g), and 424.535(a)[(x)], your Medicare supplier number [xxxxxxxxxxx] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC)

[will be revoked effective 30 days from the postmarked date of this letter]

[is revoked. The effective date of this revocation has been made retroactive to [month] [day], [year], which is the date [revocation reason]]

Pursuant to 42 CFR §424.535(c), the supplier is barred from re-enrolling for a period of [number of years] year(s) in the Medicare program from the effective date of the revocation. In order to re-enroll, you must meet all requirements for your supplier type.

[The Supplier Audit and Compliance Unit (SACU) reviewed and evaluated the documents you submitted in response to the developmental letter dated [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s).]

[The Supplier Audit and Compliance Unit (SACU) has not received a response to the developmental letter sent to you on [date]. This letter allowed you to demonstrate your full compliance with the DMEPOS supplier standards and/or to correct the deficient compliance requirement(s)]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the request for a hardship exception for the required application fee was denied. The notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application and an appeal period which you did not select.]

[The National Supplier Clearinghouse has not received a response to the developmental letter sent to you on [date] informing you that the application fee was not paid at the time you filed the CMS 855S enrollment application. The 30 day notification afforded you the opportunity to pay the mandatory application fee for processing your enrollment application]

We have determined that you are not in compliance with the supplier standards noted below:

42 CFR §424.579(c) [1-30] [Insert the specific performance standard not met]

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (A) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879(h) of the Social Security Act, you may be liable for Civil Monetary penalties.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The NSC, with Centers for Medicare & Medicaid Services (CMS) approval, may reinstate your supplier number after it reviews your CAP and any additional evidence you submit and determines you are now in compliance with all supplier standards (see 42 CFR §424.57(c)). CAP requests should be sent to:

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

If you believe that this determination is not correct, you may request reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

[National Supplier Clearinghouse Contractor name]

[Address]  
[City], ST [Zip]

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait [number of years] year(s) before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

In addition, if submitting a CMS 855s application after the re-enrollment bar has expired, 42 CFR §424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of \$50,000 for each final adverse action imposed. Therefore if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base \$50,000 amount that must be maintained.

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

Sincerely,

(Name)  
(Title)  
(Company)

**15.24.9.3 – Revocation Example #1 – Abuse of Billing**  
**(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

June 16, 2012

Bennie Scholls, D.P.M.  
4321 Bunion Road  
Excalibur WA 98234

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

Dear Dr. Scholls:

Your Medicare privileges are being revoked effective June 16, 2012 for the following reasons:

Revocation reason: 42 CFR §535(a) (8)



Specifically, you submitted 186 claims to Medicare for services provided after the date of death of 15 beneficiaries.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The CAP request must be signed and dated by the authorized or delegated official within the entity. CAP requests should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.

The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

Pursuant to 42 CFR §424.535(c), Medicare Administrative Contractor, Inc. is establishing a re-enrollment bar for a period of Three (3) years. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Joe Nail  
Provider Enrollment Analyst  
Medicare Administrative Contractor, Inc.

**15.24.9.4 – Revocation Example #2 – DMEPOS supplier revocation  
(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

May 17, 2012

Do We DME, Inc. DBA DME of Anywhere  
1500 7th Avenue  
Anywhere, PA 99999

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

Dear Do We DME, Inc. DBA DME of Anywhere:

The purpose of this letter is to inform you that pursuant to 42 CFR 405.800, 42 CFR 57(e), and 42 CFR 424.535(a)(5), your Medicare supplier number [98765432101] for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) issued by the National Supplier Clearinghouse (NSC) is revoked. The effective date of this revocation has been made retroactive to April 26, 2012, which is the date the Centers for Medicare & Medicaid Services (CMS) determined that your practice location is not operational.

Pursuant to 42 CFR 424.535(c), NSC is establishing a re-enrollment bar for a period of two (2) year from the effective date of the revocation. This enrollment bar applies only to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your supplier type.

We have determined that you are not in compliance with the supplier standards noted below:

CFR 424.57(c) (7) Maintain a physical facility on an appropriate site, accessible to the public and staffed during posted hours of business with visible signage.

Recently a representative of the NSC attempted to conduct a visit of your facility on April 26, 2012. However, the visit was unsuccessful because your facility was closed, locked, and vacant. There was a "For Rent" sign on the window along with a sign directing customers to a nearby Rite Aid Pharmacy. Because we could not complete an inspection of your facility, we could not verify your compliance with the supplier standards. Based on a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are in violation of 42 CFR 424.535(a)(5).

CFR 424.57(c) (26) must meet the surety bond requirements specified in paragraph (d) of this section (CFR 424.57(d)).

We received a cancellation notice from Cook, Books & Hyde Surety indicating that the surety bond on file with the NSC number 99999999 has been cancelled effective January 19, 2012. You failed to maintain a valid surety bond as required by law.

Section 1834 (j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the revocation of your billing numbers are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834 (a) (18) (ii) of the Social Security Act and the beneficiary has agreed to take financial responsibility if the items you supply are not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund the beneficiary as required under 1834 (j) (4) and 1879 (h) of the Social Security Act, you may be liable for Civil Monetary penalties.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

In addition, if submitting a CMS 855S application after the re-enrollment bar has expired, 42 CFR 424.57(d)(3)(ii) states suppliers will be required to maintain an elevated surety bond amount of \$50,000 for each final adverse action imposed. Therefore if you do not request a reconsideration of this decision or receive an unfavorable decision through the administrative review process, you must submit an elevated surety bond. Please note this amount is in addition to, and not in lieu of, the base \$50,000 amount that must be maintained.

The reconsideration request should be sent to:

National Supplier Clearinghouse  
P.O. Box 12345  
ATTN: Hearings and Appeals

Somewhere, AK 11111-1111

If you choose not to request a reconsideration of this decision, or you do not receive a favorable decision through the administrative review process, you must wait two (2) year(s) before resubmitting your CMS-855S application, per the re-enrollment bar cited above. Applications received in the NSC prior to this timeframe will be returned.

If you have any questions, please contact our office at (866) 238-9652 between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

Hezekiah Thigpen  
Fraud Analyst - Supplier Audit and Compliance Unit  
National Supplier Clearinghouse

**15.24.9.5 – Revocation Example #3 – MDPP Supplier Use of an Ineligible Coach**  
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

June 16, 2018

MDPP Services, Inc  
2498 Prevention Way  
Koloa, HI 96756

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

Dear MDPP Services, INC:

Your Medicare privileges are being revoked effective June 16, 2018 for the following reasons:

Revocation reason: 42 CFR §424.535(a)(1) – Not in Compliance with Medicare Requirements

Per 42 CFR §424.205(d)(3), MDPP suppliers must only use eligible coaches.

Revocation reason: 42 CFR §424.205(h)(v) – Use of an Ineligible coach

Specifically, you were notified on April 1, 2018 that John Doe was ineligible to serve as an MDPP coach due to an assault conviction in June 2015. On April 15, 2018, you submitted a corrective action plan (CAP), which removed John Doe from

Section 7 of your Form CMS-20134. On June 1, 2018, you submitted a claim with the NPI of John Doe for services rendered May 1<sup>st</sup>, after he was removed from your coach roster. This indicates knowingly use of an ineligible MDPP coach.

Revocations under 42 CFR §424.205(h)(v) are not eligible for CAP submission. The revocation becomes effective 30 days after the date of this notice.

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action. The reconsideration request should be sent to:

Medicare Administrative Contractor, Inc.  
1234 Main St. – Attn: Hearing and Appeals, Room 510  
Anytown, IL 12345

Pursuant to 42 CFR §424.205(h)(v)(B)(2), Medicare Administrative Contractor, Inc. is establishing a re-enrollment bar for a period of Three (3) years. This enrollment bar only applies to your participation in the Medicare program. In order to re-enroll, you must meet all requirements for your provider or supplier type.

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Joe Nail  
Provider Enrollment Analyst  
Medicare Administrative Contractor, Inc.

**15.24.10 – Reconsideration Guidance**  
**(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

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

**DECISION: [Provider/Supplier Name][ has/had not] provided evidence to definitely support an earlier effective date. Therefore, we [grant/cannot grant] you access to the Medicare Trust Fund (by way or issuance) of a new effective date.**

### **15.24.10.1 – Model Reconsideration Letter**

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

[month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

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

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

[specific reason]

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

[specific reason]

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

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

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

or issuance) of a Medicare number.

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

**FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ):**

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

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

The following information is required with all ALJ requests:

- Your legal business name.
- Your Medicare PTAN (if applicable).
- Tax Identification Number (TIN) or Employer Identification Number (EIN).
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision.

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov>. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the “Register New Account” form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at [https://dab.efile.hhs.gov/user\\_sessions/new](https://dab.efile.hhs.gov/user_sessions/new) to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.

And,

- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

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

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM]

Sincerely,

[Name]  
[Title]  
[Company]

**15.24.10.2 – Favorable Corrective Action Plan/Reconsideration Decision –Denials**  
**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

**Provider Enrollment & Oversight Group (PEOG)**

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Month XX, 2015

Provider/Supplier/Attorney  
[Attn:]  
Address  
City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision  
Legal Business Name: [provider/supplier name]  
NPI: XXXXXX



Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial effective Month XX, 201X. The initial determination letter by [MAC] was dated Month XX, 201X; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**DENIAL REASON: 42 CFR§ 424.530(a) (fill reason 1-11)**

- (a) Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:  
(Reason 1-11, copied from the Reg: [link](#))

[Insert language from the denial letter stating why they are being denied.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**

All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.530.

[The decision must include: A clear explanation of why PEOG is upholding the denial action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the denial, and an explanation of how the provider/supplier now meets the enrollment criteria or requirements]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**

[Enter text]

**Reconsideration:**

[Enter text]

[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**

[Enter text]

CMS grants [provider/supplier] access to the Medicare Trust Funds (by way or issuance) of a Medicare number.

This decision is a **FAVORABLE DECISION**. To effectuate this decision, CMS will direct [MAC] to allow enrollment and provide instruction, as needed, to complete the enrollment process.

Please forward any questions or concerns to [providerenrollmentappeals@cms.hhs.gov](mailto:providerenrollmentappeals@cms.hhs.gov).

Sincerely,

[Name]

[Signature]

Health Insurance Specialist

Centers for Medicare & Medicaid  
Services

cc:

[MAC]

[Provider/Supplier, if represented by an attorney]

**15.24.10.3 – Favorable Corrective Action Plan/Reconsideration  
Decision –Revocations**

(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

**Provider Enrollment & Oversight Group(PEOG)**

---

Month XX, 2015

Provider/Supplier/Attorney

[Attn:]

Address

City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision

Legal Business Name: [provider/supplier name]

NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to a revocation, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**REVOCATION REASON: 42 CFR§ 425.535 (a)(fill reason 1-14)**

- (b) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(Reason 1-14, copied from the Reg: [link](#))

[Insert language from the revocation letter stating why they are being revoked.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**

All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is upholding the revocation action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the revocation, and an explanation of how the provider/supplier now meets the enrollment criteria or requirements]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**

[Enter text]

**Reconsideration:**

[Enter text]

[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**

[Enter text]

CMS grants [provider/supplier] access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

This decision is a **FAVORABLE DECISION**. To effectuate this decision, CMS will direct [MAC] to reinstate enrollment and provide instruction, as needed, to complete the enrollment process.

Please forward any questions or concerns to [providerenrollmentappeals@cms.hhs.gov](mailto:providerenrollmentappeals@cms.hhs.gov).

Sincerely,

[Name]

[Signature]

Health Insurance Specialist

Centers for Medicare & Medicaid  
Services

cc:

[MAC]

[Provider/Supplier, if represented by an attorney]

**15.24.10.4 – Unfavorable Corrective Action Plan/Reconsideration  
Decision – Denials**

**(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)**

**Provider Enrollment & Oversight Group(PEOG)**

---

Month XX, 2015

Provider/Supplier/Attorney

[Attn:]

Address

City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision

Legal Business Name: [provider/supplier name]  
NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to an enrollment denial, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**DENIAL REASON: 42 CFR§ 424.530(a)(fill reason 1-11)**

- (c) Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:  
(Reason 1-11, copied from the Reg: [link](#))

[Insert language from the denial letter stating why they are being denied.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:

**CASE ANALYSIS:**

All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is upholding the denial action in sufficient detail for the provider to understand PEOG's decision and; if applicable: the nature of the provider's deficiencies, the regulatory basis to support each reason for the denial, and an explanation of how the provider does not meet the enrollment criteria or requirements]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**

[Enter text]

**Reconsideration:**

[Enter text]

[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**

[Enter text]

**CONCLUSION:**

CMS concludes that there is no error made by [MAC] in the determination of an enrollment denial. The [CAP and/or reconsideration] is/are denied and the denial is upheld. Therefore, CMS has decided not to grant you access to the Medicare Trust Funds (by way or issuance) of a Medicare number.

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

**FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ):**

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

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

The following information is required with all ALJ requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

**Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.** To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the “Register New Account” form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on

your behalf.

The e-mail address and password provided during registration must be entered on the login screen at [https://dab.efile.hhs.gov/user\\_sessions/new](https://dab.efile.hhs.gov/user_sessions/new) to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen. And,
- Entering and uploading the requested information and documents on the "File New Appeal – Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

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

Please forward any questions or concerns to [providerenrollmentappeals@cms.hhs.gov](mailto:providerenrollmentappeals@cms.hhs.gov).

Sincerely,

[Name]

[Signature]

Health Insurance Specialist

Centers for Medicare & Medicaid

cc:

[MAC]

[Provider, if represented by an attorney]

**15.24.10.5 – Unfavorable Corrective Action Plan/Reconsideration Decision – Revocations**

(Rev. 609, Issued: 08-14-15, Effective: 11-02-15, Implementation: 11-02-15)

**Provider Enrollment & Oversight Group(PEOG)**

---

Month XX, 2015

Provider/Supplier/Attorney

[Attn:]

Address

City, State Zip

Re: [Corrective Action Plan and/or Reconsideration] Decision

Legal Business Name: [provider/supplier name]

NPI: XXXXXX

Dear [provider/supplier/attorney]:

This letter is in response to the [Corrective Action Plan (CAP) and/or reconsideration] request received by the Centers for Medicare & Medicaid Services (CMS) in response to a revocation, effective Month XX, 2015. The initial determination letter by [MAC] was dated Month XX, 2015; therefore, this appeal is considered timely. The following decision is based on the Social Security Act, Medicare regulations, the CMS manual instructions, evidence in the file, and any information received before this decision was rendered.

**REVOCATION REASON: 42 CFR§ 425.535 (a)(fill reason 1-14)**

- (d) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(Reason 1-14, copied from the Reg: [link](#))

[Insert language from the revocation letter stating why they are being revoked.]

**SUBMITTED DOCUMENTATION [or] SUMMARY OF SUBMITTED DOCUMENTS:**

- Exhibit 1:
- Exhibit 2:



**CASE ANALYSIS:**

All of the documentation in the file for [provider/supplier name] has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535.

[The decision must include: A clear explanation of why PEOG is not holding the revocation action in sufficient detail for the provider to understand PEOG’s decision and; if applicable: the nature of the provider’s deficiencies, the regulatory basis to support each reason for the revocation, and an explanation of how the provider/supplier still does not meet the enrollment criteria or requirements.]

**[Choose which subheading is applicable- CAP, Reconsideration, or both- and delete the heading not being uses]**

**Corrective Action Plan:**

[Enter text]

**Reconsideration:**

[Enter text]

[If the CAP is approved, use this sentence: After careful consideration, CMS has approved the CAP submitted and request that the reconsideration be withdrawn.]

**DECISION:**

[Enter text]

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

**FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ):**

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

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

The following information is required with all ALJ requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

**Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov/>.** To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the “Register New Account” form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at [https://dab.efile.hhs.gov/user\\_sessions/new](https://dab.efile.hhs.gov/user_sessions/new) to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, and then clicking Civil Remedies Division on the File New Appeal screen. And,
- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights. All documents must be submitted in Portable Document Format (“PDF”). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

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

Please forward any questions or concerns to [providerenrollmentappeals@cms.hhs.gov](mailto:providerenrollmentappeals@cms.hhs.gov).

Sincerely,

[Name]

[Signature]

Health Insurance Specialist  
Centers for Medicare & Medicaid

Services

cc:

[MAC]

[Provider/Supplier, if represented by an attorney]

**15.24.11 – Reconsideration Example**

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

February 18th, 2012

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

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

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

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

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

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

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

in compliance with the enrollment requirements.

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

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

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

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

**FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE (ALJ):**

If you are satisfied with this decision, you do not need to take further action. If you believe that this determination is not correct, you may request a final ALJ review. To do this, you must file your appeal within 60 calendar days after the date of receipt of this decision by writing to the following address:

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

The following information is required with all ALJ requests:

- Your legal business name
- Your Medicare PTAN (if applicable)
- Tax Identification Number (TIN) or Employer Identification Number (EIN)
- A copy of the Hearing Officer or the CMS Regional Office (RO) decision

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <https://dab.efile.hhs.gov>. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information

requested on the “Register New Account” form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at [https://dab.efile.hhs.gov/user\\_sessions/new](https://dab.efile.hhs.gov/user_sessions/new) to access DAB E-File. A registered user’s access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.

And,

- Entering and uploading the requested information and documents on the “File New Appeal – Civil Remedies Division” form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party’s appeal rights. All documents must be submitted in Portable Document Format (“PDF”). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

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

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

Sincerely,

Muffy McGuire  
Revalidation Specialist  
Medicare Administrative Contractor Inc.

**15.24.12 – Model Identity Theft Prevention Letter**  
**(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

[month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM] and refer to your application(s) reference number [Reference number]

Sincerely,  
[Name]  
[Title]  
[Company]

**15.24.13 – Identity Theft Prevention Example**  
**(Rev. 463, Issued: 05-17-13, Effective: 04-22-13, Implementation: 06-07-13)**

May 16, 2012

Joseph Bock, M.D.  
1234 Maple Lane

Anywhere ME 12931

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

Dear Dr. Bock:

As a security precaution, we are writing to confirm that you submitted a Medicare enrollment application(s) to enroll in or change an existing enrollment at the following address:

Joseph Bock, M.D.  
4321 Oak Drive  
Anywhere ME 12910

If this application was submitted without your authorization, please contact the Medicare contractor that processes your claims immediately. The Medicare Fee-For-Service contact information can be found at [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).

We will process your application(s) according to The Centers for Medicare & Medicaid (CMS) timeliness standards and will contact you if additional information is needed. We will notify you once processing is complete.

Please contact our office with any questions at 555-555-1212 between the hours of 8 A.M. and 5 P.M. and refer to your application(s) reference number 123456789.

Sincerely,  
Boris Battles  
Security Analyst  
Medicare Administrative Contractor, Inc.

**15.24.14 – Model Documentation Request Letter**  
**(Rev. 765; Issued: 01-08-18; Effective: 01-01-18; Implementation: 01-19-18)**

[month] [day], [year]

[Provider/Supplier Name]  
[Address]  
[City] ST [Zip]

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

Dear [Provider/Supplier Name]:

[Under 42 CFR § 424.516(f)(1), a provider or supplier who furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service; and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.]

Or

[Under 42 CFR § 424.516(f) (2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain documentation for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request. The documentation to be maintained includes written and electronic documents relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.]

Or

[Under 42 CFR §424.205(g), an MDPP supplier is required to maintain documentation for 10 years from the date of services and to provide access to that documentation pursuant to a CMS or Medicare contractor request.]

Consistent with [§ 424.516(f) [(x)] or §424.205(g)], please mail to us copies of the orders for the items or services that were furnished to the following beneficiaries on the dates specified:

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

[Beneficiary name] [Identification information] [Dates provider/supplier furnished items/services]

(etc.)



The documentation must be received at the following address no later than 30 calendar days after the date of this letter:

[Name of MAC]

[Address]

[City], ST [Zip]

Failure to timely submit this documentation may result in the revocation of your Medicare billing privileges pursuant to 42 CFR § 424.535(a) (10).

[Name]

[Title]

[Company]

[Title]

[Company]

**15.24.15 – Model Deactivation Letter**

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

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

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY] pursuant to:

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)[1-2]

[Specific reason for the deactivation of the provider/supplier’s Medicare billing privileges.]

(If the deactivation is under 424.540(a)(1), an example narrative may include:

[MAC Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than twelve calendar months from the date of this letter.)

(If the deactivation is under 424.540(a)(2), an example narrative may include:

[MAC Name] has been informed that John Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies John Smith as a 5% or greater owner. [MAC Name] has not received a Medicare enrollment application reporting this change in ownership.)

**REBUTTAL RIGHTS:**

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 20 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the provider/supplier wishes to appoint a legal representative that is not an attorney to sign the rebuttal, the provider/supplier must include with the rebuttal a written notice authorizing the legal representative to act on the provider/supplier's behalf. The notice should be signed by the provider/supplier.

If the provider/supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that he/she has the authority to represent the provider/supplier.

If you wish to receive communication regarding your rebuttal via email, please include a valid email address in your rebuttal submission.

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name] [Title] [Company]

**15.24.16.3.4 – Opt-out Return Letter – Withdraw of Affidavit  
During Processing**

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

[month] [day], [year]

[Eligible Practitioner Name] [Address] [City] ST [Zip]

Reference: Case/Control Number

Dear [Eligible Practitioner Name]:

[Insert MAC] is returning your Medicare opt-out affidavit, submitted on [insert date], because you have decided to withdraw your opt-out affidavit while it is still in process.

For questions concerning this letter, contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Name]  
[Title]  
[Company]

## **15.25 – Appeals Process**

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

### **A. Background**

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privileges are revoked may request an appeal of that determination. Change of information request denials, reassignment denials, and effective date determinations for initial enrollments may also be appealed.

This appeal process applies to all providers and suppliers - not merely those defined in 42 CFR Part 498 - and ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act (MMA), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a reconsideration decision to an administrative law judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers may thereafter seek review by the Departmental Appeals Board (DAB) and may then request judicial review.

### **B. Notification Letters for Denials and Revocations**

If a Medicare contractor finds a legal basis for denying an application - and, if applicable under section 15.8.4 of this chapter, receives approval from the Provider

Enrollment & Oversight Group (PEOG) for said denial - the contractor shall deny the application and notify the provider or supplier by letter. The denial letter shall contain:

- A legal (i.e., regulatory) basis for each reason for the denial;
- A clear explanation of why the application is being denied, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- Procedures for submitting a corrective action plan (CAP); and
- Complete and accurate information about the provider or supplier's further appeal rights.

Similarly, when a Medicare contractor discovers a basis for revoking a provider or supplier's enrollment - and, if applicable under section 15.27.2 of this chapter, receives approval from PEOG for the revocation - the contractor shall revoke billing privileges and notify the provider or supplier by letter. The revocation letter shall contain:

- A legal (i.e., regulatory) basis for each reason for revocation;
- A clear explanation of why Medicare billing privileges are being revoked, including the facts or evidence that the contractor used in making its determination;
- An explanation of why the provider or supplier does not meet the applicable enrollment criteria;
- The effective date of the revocation (see section 15.27.2(C) of this chapter for more information);
- Procedures for submitting a CAP; and
- Complete and accurate information about the provider or supplier's further appeal rights.

### **15.25.1 - Appeals Involving Non-Certified Suppliers (Rev. 440, Issued: 11-23-12, Effective: 12-24-12, Implementation: 12-24-12)**

Sections 15.25.1.1 through 15.25.1.3 below apply to:

- Individuals and solely-owned entities completing the Form CMS-855I

- Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
- Suppliers completing the Form CMS-855B, with the exception of ambulatory surgical centers and portable x-ray suppliers

**15.25.1.1 – Corrective Action Plans (CAPs)**  
**(Rev. 676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)**

**A. Requirements and Submission of CAPs**

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its enrollment. The CAP must:

- (1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;
- (2) Be submitted within 30 days from the date of the denial or revocation notice;
- (3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;
- (4) For revocations, be based on §424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than §424.535(a)(1) shall not be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) If the supplier submits a CAP that does not comply with this paragraph, the contractor shall notify the supplier via letter or e-mail that it cannot be considered. (If multiple grounds are involved of which one is (a)(1), the contractor shall:

- Only consider the portion of the CAP pertaining to (a)(1), and
- Notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under §405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.)

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above:

- Denials - The contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.
- Revocations – The contractor shall not contact the supplier for the missing information or documentation. It shall simply deny the CAP. (Under §405.809(a)(2), the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.)

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP.

## **B. Processing and Approval of CAPs**

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements. Consider the following examples:

*1.* Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

*2.* Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

### **C. Concurrent Submission of CAP and Reconsideration Request**

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It cannot be appealed.
- The contractor shall notify the supplier of the denial via letter.
- The supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if submitted, shall be processed.

### **15.25.1.2 – Reconsideration Requests – Non-Certified Providers/Suppliers**

**(Rev. 734; Issued: 07-28-17; Effective: 06-27-17; Implementation: 06-27-17)**

**NOTE:** This section 15.25.1.2 does not apply to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4), §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3). Such reconsiderations are addressed in section 15.25.2.2 below.

#### **A. Timeframe for Submission**

A supplier that wishes to request a reconsideration must file its request in writing with the Medicare contractor within 60 days from the supplier's receipt of the notice of denial or revocation to be considered timely filed. Per 42 CFR §498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. A reconsideration request submitted on the 65<sup>th</sup> 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**

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

#### **A. Administrative Law Judge (ALJ) Hearing**

CMS, a Medicare contractor, or a supplier dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

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

(ALJ requests can also be submitted electronically at <https://dab.efile.hhs.gov/>.)

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the supplier, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

The following are examples of information the Medicare contractor may be asked to provide:

- A copy of the initial determination letter.
- A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.
- The HO's decision; including the provider's CAP or reconsideration request.
- A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.
- All background information and investigative data that the HO used to make their decision. Including any on-site visit reports; the contractor's recommendation for administrative action based on the on-site visit;
- Contact information for the person(s) who signed both the revocation and reconsideration letters.
- This is not an exhaustive list.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in

PEOG providing specific instructions to the contractor to modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns, modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the settlement or ALJ decision no later than 5 business days from the date it received PEOG's specific instructions.

## **B. Departmental Appeals Board (DAB) Hearing**

CMS or a supplier dissatisfied with the ALJ hearing decision may request a Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the contractor of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the DAB decision no later than 5 business days from the date it received PEOG's specific instructions.

## **C. Judicial Review**

A supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed

within 60 days from receipt of the notice of the DAB's decision.

## **15.25.2 - Appeals Involving Certified Providers and Certified Suppliers**

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

Sections 15.25.2.1 through 15.25.2.3 below apply to:

- Providers and suppliers completing the Form CMS-855A
- Ambulatory surgical centers
- Portable x-ray suppliers
- Also, section 15.25.2.2 applies to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4), §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14) and reconsiderations of denials based wholly or partially on §424.530(a)(3), regardless of provider or supplier type.

### **15.25.2.1 – Corrective Action Plans (CAPs)**

**(Rev. 676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)**

#### **A. Submission of CAPs**

The CAP process gives a provider or supplier (hereinafter collectively referred to as “providers”) an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its enrollment. The CAP must:

- (1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;
- (2) Be submitted within 30 days from the date of the denial or revocation notice;
- (3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.
- (4) For revocations, be based on §424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) cannot be accepted. (For revocations based on multiple grounds of which one is §424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) CMS' Provider Enrollment & Oversight Group (PEOG), which processes all CAPs, will notify the provider if a CAP cannot be accepted.

CAP requests must be sent to the following address:

Centers for Medicare & Medicaid Services  
Center for Program Integrity  
Provider Enrollment & Oversight Group  
7500 Security Boulevard  
Mailstop AR 18-50  
Baltimore, MD 21244-1850

If the contractor inadvertently receives a CAP request, it shall immediately forward it to PEOG at this address or, if possible, to the following PEOG mailbox: [providerenrollmentappeals@cms.hhs.gov](mailto:providerenrollmentappeals@cms.hhs.gov).

Also:

- PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.
- The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

#### **B. Processing and Approval of CAPs**

PEOG will process a CAP within 60 days. During this period, PEOG will not toll the filing requirements associated with a reconsideration request.

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and permit or restore enrollment (as applicable), and (2) notify the provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

If the CAP is denied:

- It cannot be appealed.
- PEOG will notify the provider or supplier of the denial via letter.
- The provider or supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if submitted, will be processed.

#### **15.25.2.2 – Reconsideration Requests – Certified Providers and Certified Suppliers** (Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)

This section 15.25.2.2 also applies to reconsiderations of revocations based wholly or partially on §424.535(a)(2), §424.535(a)(3), §424.535(a)(4) or §424.535(a)(8), §424.535 (a)(13), and §424.535 (a)(14), and reconsiderations of denials based wholly or partially on §424.530(a)(3), regardless of provider or supplier type.

#### **A. Timeframe for Submission**

A provider that wishes to request a reconsideration must submit its request, in writing, to CMS' PEOG within 60 days from the supplier's receipt of the notice of denial or revocation to be considered timely filed. Per 42 CFR §498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. The mailing address is:

Centers for Medicare & Medicaid Services  
Center for Program Integrity  
Provider Enrollment & Oversight Group  
7500 Security Boulevard  
Mailstop AR-18-50  
Baltimore, MD 21244-1850

PEOG will extend the filing period an additional 5 days to allow for mail time. A reconsideration request submitted on the 65<sup>th</sup> 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](mailto:providerenrollmentappeals@cms.hhs.gov).

### **D. Reconsideration Determination**

As already stated, if a timely request for a reconsideration is made, PEOG will consider the request and issue a determination within 90 days of the request.

The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

The contractor shall work with and provide PEOG with all necessary documentation.

The following are examples of information the Medicare contractor will be asked to provide:

- A copy of the initial determination letter.
- A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.
- A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.
- This is not an exhaustive list.

The contractor shall supply PEOG with all requested documentation within 5

business days.

If the appealing party has additional information that it would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, the party must submit that information with its request for reconsideration. This is the party's only opportunity to submit information during the administrative appeals process; the party will not have another opportunity to do so unless an administrative law judge specifically allows the party to do so under 42 CFR §498.56(e).

PEOG may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

### **E. Issuance of Reconsideration Decision**

PEOG will issue a written decision within 90 days of the date of the request. It will: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the provider or the individual who signed the reconsideration request. The reconsideration letter will include:

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;
- A summary of the documentation that the provider furnished;
- A clear explanation of why PEOG is upholding or overturning the denial or revocation action in sufficient detail for the provider to understand PEOG's decision and, if applicable, the nature of the provider's deficiencies;
- If applicable, the regulatory basis to support each reason for the denial or revocation;
- If applicable, an explanation of how the provider does not meet the enrollment criteria or requirements;
- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the address to which the written appeal must be mailed or e-mailed; and
- Information that the provider must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and issue or restore billing privileges (as applicable), and (2) notify the

provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

#### **F. Withdrawal of Reconsideration Request**

The provider or the individual who signed the reconsideration request may withdraw its request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with PEOG at the address in (A) above.

### **15.25.2.3 – Additional Appeal Levels**

**(Rev. 688, Issued: 11-18-16, Effective: 07-26-16, Implementation: 07-26-16)**

#### **A. Administrative Law Judge (ALJ) Hearing**

CMS, a Medicare contractor, or a provider dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

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

(ALJ requests can also be submitted electronically at <https://dab.efile.hhs.gov/>.)

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

Upon receipt of a request for an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider, CMS and the Regional Office of General Counsel (OGC) acknowledging receipt of an appeals request and detailing a scheduled pre-hearing conference. The OGC will assign an attorney to represent CMS during the appeals process; he/she will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing to discuss any issues. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation. This includes compiling and sending all relevant case material to the OGC attorney upon the latter's request within 5 calendar days of said request.

The following are examples of information the Medicare contractor may be asked to provide:

- A copy of the initial determination letter.
- A chronological timeline outlining the processing of applications, the date they began providing services at the newest assigned location, and if there were information request; including the CAP and/or reconsideration request.
- The HO's decision; including the provider's CAP or reconsideration request.
- A complete copy of Form CMS-855, and any supporting documentation submitted with the provider's application.
- All background information and investigative data that the HO used to make their decision. Including any on-site visit reports; the contractor's recommendation for administrative action based on the on-site visit;
- Contact information for the person(s) who signed both the revocation and reconsideration letters.
- This is not an exhaustive list.

Any settlement proposals, as a result of the pre-hearing conference, will be addressed with CMS. If CMS agrees to settle a provider enrollment appeal, CMS will notify the contractor of appropriate next steps (e.g. changing the effective date of billing privileges or reinstating a provider's billing privileges). This may result in PEOG providing specific instructions to the contractor to modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

If an ALJ decision is rendered that overturns, modifies the initial determination establishing an effective date, revocation or denial of billing privileges, or remands a case back to CMS, this may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the settlement or ALJ decision no later than 5 business days from the date it received PEOG's specific instructions.

## **B. Departmental Appeals Board (DAB) Hearing**

The CMS or a provider dissatisfied with the ALJ hearing decision may request a

Board review by the DAB. Such a request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a DAB review is deemed to be a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing to make its determination. The DAB may admit additional evidence into the record if the DAB considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. If additional information is presented orally to the DAB, a transcript will be prepared and made available to any party upon request.

When CMS receives a decision or order from the DAB, as appropriate, PEOG will notify the contractor of appropriate next steps (i.e. changing an effective date or reinstating a provider's billing privileges). This may also result in PEOG providing specific instructions to the contractor to draft and issue a revised reconsideration decision and/or modify template letter language to appropriately notify the provider of changes to its enrollment status, revocation effective date, or effective date of billing privileges.

The contractor shall complete all steps associated with the DAB decision no later than 5 business days from the date it received PEOG's specific instructions.

### **C. Judicial Review**

A provider dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such a request shall be filed within 60 days from receipt of the notice of the DAB's decision.

## **15.26.2 – Capitalization**

**(Rev. 362, Issued: 12-17-10, Effective: 01-01-11, Implementation: 01-01-11)**

### **A. Background**

Effective January 1, 2011, and pursuant to 42 CFR §489.28(a) and §424.510(d)(9), an HHA entering the Medicare program - including a new HHA as a result of a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds, which we term initial reserve operating funds, at (1) the time of application submission, and (2) all times during the enrollment process, to operate the HHA for the three-month period after Medicare billing privileges are conveyed by the Medicare contractor (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the 3-month period following the conveyance of Medicare billing privileges.

## **B. Points of Review**

At a minimum, the contractor shall verify that the HHA meets the required amount of capitalization:

1. Prior to making its recommendation for approval;
2. After a recommendation for approval is made but before the RO review process is completed;
3. After the RO review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and
4. During the 3-month period after the contractor conveys Medicare billing privileges to the HHA.

The HHA must submit proof of capitalization within 30 calendar days of being requested to do so by the contractor. Should the HHA fail to furnish said proof and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to §424.530(a)(8)(i) or (ii), as applicable. If billing privileges have been conveyed, the contractor shall revoke the HHA's billing privileges per §424.535(a)(11).

Should the contractor believe it is necessary to verify the HHA's level of capitalization more than once within a given period, e.g., more than once between the time a recommendation is made and the completion of the RO review process – the contractor shall seek approval from its DPSE liaison.

## **C. Determining Initial Reserve Operating Funds**

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR §489.28(a) if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of 3 or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first 3 months of operation--or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs--whichever is greater.

The contractor shall determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least 3 HHAs that the contractor serves that are comparable to the HHA that is seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- Geographic location and urban/rural status;
- Number of visits;

- Provider-based versus free-standing status; and
- Proprietary versus non-proprietary status.

The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first 3 months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

#### **D. Proof of Operating Funds**

The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, must include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA.

In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds.

As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

#### **E. Borrowed Funds**

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed

funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

#### **F. Line of Credit**

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

#### **G. Documents**

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the provider:

- A document outlining the provider's projected budget – preferably, a full year's budget broken out by month
- A document outlining the number of anticipated visits - preferably a full year broken out by month
- An attestation statement from an officer of the HHA defining the source of funds
- Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)
- Letter from officer of the bank attesting that funds are available
- If available, audited financial statements

The contractor shall also ensure that the capitalization information in section 12, of the CMS-855A is provided.

#### **15.26.3 – Additional Home Health Agency (HHA) Review Activities (Rev. 492, Issued: 12-06-13, Effective: 01-07-14, Implementation: 01-07-14)**



As stated in section 15.26.2(B)(3) of this chapter, the contractor must verify that a newly enrolling HHA has the required amount of capitalization after the regional office (RO) review process is completed but before the contractor conveys Medicare billing privileges to the HHA. Accordingly, the HHA must submit proof of capitalization during this “post-RO review” period.

To confirm that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement, the contractor shall also – during the post-RO review period ensure that each entity and individual listed in sections 2, 5 and 6 of the HHA’s Form CMS-855A application is again reviewed against the Medicare Exclusion Database (MED) and the System for Award Management (SAM) (formerly the General Services Administration (GSA) Access Management System). This activity applies: (1) regardless of whether the HHA is provider-based or freestanding, and (2) only to initial enrollments.

The capitalization and MED/SAM re-reviews described above shall be performed once the RO notifies the contractor via e-mail that the RO’s review is complete. (Per sections 15.4.1.6 and 15.19.2.2 of this chapter, a site visit will be performed after the contractor receives the tie-in/approval notice from the RO but before the contractor conveys Medicare billing privileges to the HHA.) If:

- a. The HHA is still in compliance** (e.g., no owners or managing employees are excluded, capitalization is met):
  1. The contractor shall notify the RO of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.
  2. The RO will: (1) issue a CMS Certification Number (CCN), (2) sign a provider agreement, and (3) send a tie-in notice or approval letter to the contractor. Per section 15.7.7.2.1 of chapter 15, the contractor shall complete its processing of the tie-in notice/approval letter within 45 calendar days of receipt (during which time a site visit will be performed).
- b. The HHA is not in compliance** (e.g., capitalization is not met):
  1. The contractor shall deny the application in accordance with the instructions in this chapter and issue appeal rights. (The denial date shall be the date on which the contractor completed its follow-up capitalization and MED/SAM reviews.)
  2. Notify the RO of the denial via e-mail. (PEOG, not the RO, will handle any CAP or appeal related to the contractor’s denial.)

While, therefore, the process of enrolling certified suppliers and certified providers

other than HHAs remains the same (i.e., recommendation is made to State/RO, after which the RO sends tie-in notice to contractor, etc.), the HHA process contains additional steps – specifically, Steps 4 and 5, as outlined below:

1. Contractor processes incoming HHA application and either (1) denies application, or (2) recommends approval to State/RO.
2. State performs survey (if applicable) and makes recommendation to RO.
3. If State recommends approval and RO concurs, RO will – instead of issuing CCN, signing provider agreement and sending tie-in notice/approval letter to contractor at this point, as is done with other certified provider and certified supplier applications – notify contractor that its review is complete.
4. Upon receipt of RO’s notification, contractor will perform capitalization and MED/SAM reviews discussed in sections 15.26.2 and 15.26.3 of this chapter.
5. Once contractor completes its review, it will notify RO as to whether HHA is still in compliance with enrollment requirements.

## **15.27 – Deactivations and Revocations**

**(Rev. 354, Issued: 08-27-10, Effective: 09-28-10, Implementation: 09-28-10)**

If circumstances warrant, a fee-for-service contractor shall deactivate or revoke a provider or supplier’s Medicare billing privileges under certain circumstances. Deactivation or revocation of Medicare billing privileges will not impact a provider or supplier’s ability to submit claims to non-Medicare payers using their National Provider Identifier.

### **15.27.1.2 – Reactivations**

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

Sections 15.27.1.2.1 through 15.27.2.2 below discuss the requirements for reactivating a provider or supplier’s billing privileges.

If the contractor approves a provider or supplier’s reactivation application or reactivation certification package (RCP) for a Part B non-certified supplier, the reactivation effective date shall be based on the date the contractor received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the contractor shall issue a new Provider Transaction Access Number (PTAN) unless otherwise stated in this chapter.

Contractors shall grant retrospective billing privileges in accordance with Section 15.17(B) for reactivating providers and suppliers, unless otherwise stated in this

chapter. This includes providers that were deactivated for not responding to a revalidation request.

With the exception of HHAs, reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement. Per 42 CFR § 424.540(b)(3)(i), an HHA must undergo a new State survey or obtain accreditation by an approved accreditation organization before its billing privileges can be reactivated. (See section 15.26.3 of this chapter for more information.)

### **15.27.1.2.1 – Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim**

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

#### **A. Background**

To reactivate its billing privileges, a provider or supplier deactivated for failing to timely notify the contractor of a change of information (see section 15.27.1.1(A) above) must either:

1. Submit a complete Medicare enrollment application, or
2. Recertify that its enrollment information currently on file with Medicare is correct.

#### **B. Certification Option**

##### **1. General Requirements**

To utilize option (A)(2) above, the provider or supplier must submit to the contractor (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 or Form CMS-20134 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, and (c) a letter certifying as to the data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the

provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).

(v) Contain the following language:

For Individual Practitioners

“I, \_\_\_\_\_, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them.”

For Authorized/Delegated Officials

“I, \_\_\_\_\_, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

A separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record (and the PTANs in that record) the provider or supplier seeks to have reactivated. To illustrate, suppose a supplier has three separate enrollments it wants to reactivate. Each enrollment has its own PECOS enrollment record. Two of the records have one PTAN; the third record contains two PTANs. The supplier must submit three separate PECOS Web printouts, three separate certification statements, and three separate letters. (The letter pertaining to the third enrollment record must list both PTANs.) The certification statement and letter should be attached to the PECOS Web printout to which it pertains – meaning, per our example, that there would be three separate “reactivation certification packages” (RCPs). All RCPs must be submitted via mail. They cannot be faxed or e-mailed.

The provider or supplier cannot utilize the certification option and must submit a complete Form CMS-855 or Form CMS-20134 application if:

- There is any information in the provider or supplier's PECOS Web enrollment record that is not correct.
- The provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS).
- The provider or supplier cannot otherwise produce a valid RCP.

## 2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (B)(1) above. If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.
- Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).
- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).
- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.
- Reserves the right to request a full Form CMS-855 or Form CMS-20134 application if the contractor has reason to believe that any data in the provider's enrollment record is inaccurate or outdated. However, it shall obtain the approval of its CMS Provider Enrollment Business Function Lead (PEBFL) before making this request.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.1(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider is operational per the site visit, and (5) for HHAs, has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (As stated earlier, though, rejection is appropriate if the provider does not adequately respond to the provider's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its CMS Provider Enrollment

Business Function Lead (PEBFL) for guidance.

### **15.27.1.2.2 – Reactivations - Deactivation for Non-Submission of a Claim**

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

To reactivate its billing privileges, a provider or supplier deactivated for non-billing must recertify that its enrollment information currently on file with Medicare is correct. This section discusses this requirement.

#### **A. All of Provider's Data in Enrollment Record Is Correct**

##### **1. General Requirements**

If all of the data in the provider or supplier's enrollment record is correct, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 or Form CMS-20134 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (c) the claim data described in section 15.27.1.2.3(B) of this chapter, and (d) a letter certifying as to the data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).
- (v) Contain the following language:

##### For Individual Practitioners

"I, \_\_\_\_\_, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

“I, \_\_\_\_\_, in my capacity as an authorized or delegated official of (Provider/Supplier), certify on behalf of (Provider/Supplier) that all of the information contained in (Provider/Supplier’s) Medicare enrollment record (the record’s PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (Provider/Supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

As explained in section 15.27.1.2.2(A), a separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All such “reactivation certification packages” (RCPs) must be submitted via mail. They cannot be faxed or emailed.

## 2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (A)(1) above.

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider’s enrollment record against the Medicare Exclusion Database (MED) and the System for Award Management (SAM).

- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).

- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(A), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, and (5) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its CMS Provider Enrollment Business Function Lead (PEBFL) for guidance.

## **B. Some of Provider's Data in Enrollment Record Is Incorrect**

### 1. General Requirements

If any data in the provider or supplier's enrollment record is incorrect, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) applicable hard-copy page(s) of the Form CMS-855 or Form CMS-20134 containing the corrected information (e.g., new section 8 reporting a change to the billing company address), (c) a certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (d) the claim data described in section 15.27.1.2.3(B) of this chapter, and (e) a letter certifying as to the rest of the enrollment data's accuracy. The letter must:

- (i) Be on the provider or supplier's letterhead.
- (ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), NPI, and PTAN(s).
- (iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.
- (iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 or Form CMS-20134 certification statement).
- (v) Contain the following language:

For Individual Practitioners



“I, \_\_\_\_\_, certify that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted Form CMS-855 pages) - all of the information currently contained in Medicare enrollment record (the record’s PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them.”

For Authorized/Delegated Officials

“I, \_\_\_\_\_, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted [Form CMS-855 or Form CMS-20134] pages) - all of the information contained in (provider/supplier’s) Medicare enrollment record (the record’s PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed [Form CMS-855 or Form CMS-20134] certification statement and agrees to abide by them.”

As explained in section 15.27.1.2.2(B), a separate Form CMS-855 or Form CMS-20134 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All RCPs must be submitted via mail. They cannot be faxed or emailed.

## 2. Contractor Processing

Upon receipt of an RCP, the contractor:

- Shall ensure that it is complete and contains all of the elements identified in (B)(1) above.

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the letter does not identify the information in the enrollment record that is incorrect; (4) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (5) the certification statement or letter is undated; (6) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- Shall review all names listed in the provider's enrollment record against the MED and the SAM.
- Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).
- Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.
- Process the changed information in accordance with the instructions in this chapter. The entire RCP transaction (including the changed data) shall, however, be processed as a revalidation.

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, (5) all of the changed information can be processed to approval, and (6) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its (PEBFL) for guidance.

### **C. PECOS Web Printout**

If the provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS) or cannot otherwise submit a valid RCP, it must submit a complete Form CMS-855 or Form CMS-20134 application in order to reactivate its Medicare billing privileges.

## **15.27.1.2.3 – Reactivations – Miscellaneous Policies**

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

### **A. Full Enrollment Applications**

1. For providers that were deactivated for non-billing, the provider may submit a complete Form CMS-855 or Form CMS-20134 enrollment application in lieu of an RCP. The application may be submitted via paper or PECOS Web.
2. For Form CMS-855 or Form CMS-20134 reactivation applications, the

timeliness requirements in sections 15.6.1 et seq., pertaining to initial enrollment applications apply. The contractor shall – unless a CMS instruction directs otherwise - validate all of the information on the application just as it would with an initial application.

3. Unless stated or indicated otherwise:

- The term “Form CMS-855 revalidations” or “Form CMS-20134 revalidations” as used in this chapter 15 only includes Form CMS-855 or Form CMS-20134 revalidation applications. It does not include RCPs.
- The term “revalidation” as used in this chapter 15 includes Form CMS-855 or Form CMS-20134 revalidation applications and RCPs.

## **B. Claims**

For RCP submissions, the provider must also furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. Alternatively, the provider may include in its RCP letter the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.

## **C. Development**

If the initial RCP is incomplete or inadequate and the contractor initiates development procedures, the following principles apply:

- The provider may submit the requested documentation to the contractor via scanned email, fax or mail.
- If there are deficiencies in the RCP letter, the provider must submit (1) a new letter, and (2) a newly-signed and dated certification statement (The certification statement may be submitted by the provider via scanned email, fax or mail). The provider cannot mark-up the previous letter and resubmit it.

## **15.27.2 – Revocations**

*(Rev. 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.

## 2. Revocation Reason 2 (42 CFR §424.535(a)(2)) – Excluded/Debarred from Federal Program

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) Excluded from the Medicare, Medicaid, and any other federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

If an excluded party is found, the contractor shall notify its CMS PEOG Business Function Lead (PEOG BFL) immediately. PEOG will notify the Contracting Officer's Representative (COR) for the appropriate *Unified* Program Integrity

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

### 3. Revocation Reason 3 (42 CFR §424.535(a)(3)) – Felony Conviction

The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR §1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. Offenses include, but are not limited in scope and severity to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

An enrollment bar issued pursuant to 42 CFR §424.535(c) does not preclude CMS or its contractors from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all criteria necessary to enroll in Medicare.

### 4. Revocation Reason 4 (42 CFR §424.535(a)(4)) – False or Misleading Information on Application

The provider or supplier certified as “true” misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)

### 5. Revocation Reason 5 (42 CFR §424.535(a)(5)) - On-Site Review/Other Reliable Evidence that Requirements Not Met

Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

- (i) Is not operational to furnish Medicare-covered items or services; or
- (ii) Otherwise fails to satisfy any Medicare enrollment requirement.

6. Revocation Reason 6 (§424.535(a)(6)) - Hardship Exception Denial and Fee Not Paid

- (i) (A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or  
  
(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.
- (ii) (A) Either of the following occurs:
  - (1) CMS is not able to deposit the full application amount into a government-owned account; or
  - (2) The funds are not able to be credited to the United States Treasury;(B) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or  
  
(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

7. Revocation Reason 7 (42 CFR §424.535(a)(7)) – Misuse of Billing Number

The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers that enter into a valid reassignment of benefits as specified in 42 CFR §424.80 or a change of ownership as outlined in 42 CFR §489.18.

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

Abuse of billing privileges includes either of the following:

- (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined in §424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

**(NOTE:** With respect to (a)(8), PEOG --rather than the contractor --will (1) make all determinations regarding whether a provider or supplier has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; (3) accumulate all information needed to make such determinations; and (4) prepare and send all revocation letters.)

**9. Revocation Reason 9 (42 CFR §424.535(a)(9)) – Failure to Report Changes The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.**

With respect to Revocation Reason 9:

- This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and



organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

- If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR §424.535(a)(5)(ii) or via another verification process - that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking PEOG's approval to revoke).

10. Revocation Reason 10 (42 CFR §424.535(a)(10)) – Non-Compliance with Documentation Requirements

The provider or supplier did not comply with the documentation requirements specified in 42 CFR §424.516(f).

11. Revocation Reason 11 (42 CFR §424.535(a)(11)) - Home Health Agency (HHA) Capitalization

A home health agency (HHA) fails to furnish - within 30 days of a CMS or Medicare contractor request - supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR §489.28(a).

12. Revocation Reason 12 (42 CFR §424.535(a)(12)) – Medicaid Billing Privileges Revoked

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

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

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

- (i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or
- (ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

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

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

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

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

## **B. Prior PEOG Approval**

### 1. Prior PEOG Approval Necessary

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

### 2. Prior PEOG Approval Unnecessary

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

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

## **C. Effective Date of Revocations**

Per 42 CFR §424.535(g), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier. However, a revocation based on a: (1) Federal exclusion or debarment; (2) felony conviction as described in 42 CFR §424.535(a)(3); (3) license suspension or revocation; or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational. As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the

provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed (with prior PEOG approval) if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- Need not solicit or ask for such proof in its revocation letter. It is up to the provider/supplier to furnish this data on its own volition.
- Has the discretion to determine whether sufficient “proof” exists.

## **D. Re-enrollment Bar**

### 1. Background

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

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

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

### 2. Establishment of Length

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

- §424.535(a)(1) (Noncompliance) -- For licensure issues, 1 year if no billing after loss of license; 3 years if billing after loss of license; 3 years for violation of a Medicare policy (using certification statement)

- §424.535(a)(2) (Provider or Supplier Conduct) – 3 years
- §424.535(a)(3) (Felonies) – 3 years
- §424.535(a)(4) (False or Misleading Information) – 3 years
- §424.535(a)(5) (Onsite Review) – 2 years
- §424.535(a)(6) (Grounds Related to Screening) – 1 year
- §424.535(a)(7) (Misuse of Billing Number) – 3 years
- §424.535(a)(8) (Abuse of Billing) – 3 years
- §424.535(a)(9) (Failure to Report) -1 year if licensure, practice location, revocation; 3 years if felony or exclusion
- §424.535(a)(10) (Failure to Provide CMS Access) – 1 year
- §424.535(a)(11) (Initial Reserve Operating Funds) – 1 year
- §424.535(a)(12) (Medicaid Termination) – 2 years
- §424.535(a)(13) (Prescribing Authority) – 2 years
- § 424.535(a)(14) (Improper Prescribing Practices) – 3 years

### 3. Applicability of Bar

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

- John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under §424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.
- Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was

revoked under §424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.

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

### **E. Submission of Claims for Services Furnished Before Revocation**

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

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

### **F. Timeframe for Processing of Revocation Actions**

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

### **G. Provider Enrollment Appeals Process**

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

### **H. Summary**

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

- Preparing a draft revocation letter;

- E-mailing the letter to PEOG via the [ProviderEnrollmentRevocations@cms.hhs.gov](mailto:ProviderEnrollmentRevocations@cms.hhs.gov) mailbox with additional pertinent information regarding the basis for revocation;
- Receiving PEOG’s determinations and abiding by PEOG’s instructions regarding the case;
- If PEOG authorizes the revocation:
  - Revoking the provider’s billing privileges back to the appropriate date;
  - Establishing the applicable reenrollment bar;
  - Updating PECOS to show the length of the reenrollment bar;
  - Assessing an overpayment, as applicable; and
  - Affording appeal rights.

**I. Reporting Revocations/Terminations to the State Medicaid Agencies and Children’s Health Program (CHIP)**

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

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

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

Appeal Submitted:

Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)

No - (definition: no appeal of any type has been submitted)

Appeal Type:

CAP

Reconsideration

ALJ

DAB

Appeal Status:

Under Review

Revocation Upheld

Revocation Overturned

Denial Upheld

Denial Overturned

CAP accepted

CAP denied

Reconsideration Accepted

Reconsideration Denied

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

If an appeal action has been submitted to PEOG for certified providers or suppliers, contractors shall access the PEOG appeals log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to its designated PEBFL.

## **J. Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers**

The contractor need not obtain prior approval from the state/RO prior to revoking a certified provider or certified supplier's billing privileges. When revoking the provider/supplier, however, the contractor shall:

- E-mail a copy of the revocation letter to the applicable RO's Division of Survey & Certification corporate mailbox. (The RO will notify the state of the revocation.)
- After determining the effective date of the revocation, end-date the entity's enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in the same manner as it would upon receipt of a tie-out notice from the RO.

Afford the appropriate appeal rights per section 25 of this chapter.

### **K. Overpayments Based Upon Revocations**

In situations where a revocation is made with a prospective (i.e., 30 days from the date of CMS or the contractor's mailing of the revocation notification letter to the provider) effective date, the contractor 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](mailto:ProviderEnrollmentAppeals@cms.hhs.gov) within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

## **B. Time Calculations for Rebuttal Submissions**

The date of receipt of a deactivation notice is presumed to be 5 days after the date on the deactivation notice unless there is a showing that it was, in fact, received earlier or later.

Therefore, the rebuttal must be received within 20 calendar days from the date of the deactivation notice to be considered timely. If the 20<sup>th</sup> 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 20<sup>th</sup> 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 20<sup>th</sup> calendar day from the date on the deactivation notice.

It is the provider's or supplier's responsibility to timely update its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to its correspondence address. Failure to timely update a

correspondence address or other addresses included in its Medicare enrollment record does not constitute an “in fact” showing that the deactivation notice was received after the presumed receipt date (as described above).

### **C. Processing Rebuttal Submissions**

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

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

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

- 1) For deactivations under 42 C. F. R. § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the twelve month period preceding the date of deactivation, starting with the 1st day of the 1st month twelve months prior to the date of deactivation. If it is confirmed that billing occurred within twelve months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the twelve month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination.

Consider the following example:

Dr. Awesome has been enrolled in the Medicare program since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2016. Dr. Awesome’s enrollment is deactivated effective January 1, 2018. Dr. Awesome timely submits a rebuttal statement regarding the deactivation. Upon the contractor’s review of the submitted documentation and internal records, it is confirmed that Dr. Awesome had not submitted claims since January 2016. Therefore, an unfavorable determination would be appropriate in this scenario, as the deactivation was justified.

- 2) For deactivations under 42 C. F. R. § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine

whether the change of information was properly submitted within 90 calendar days of when the change occurred. If information was submitted properly and timely, the contractor shall approve the rebuttal request and reinstate the provider's or supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, as the deactivation was justified. In making this determination, the contractor shall consider, at minimum, the following.

- a. Whether the deactivation was implemented after 90 days of when the change of enrollment information occurred.
- b. Whether the letter notifying the provider or supplier of the deactivation was sent to the correct address as instructed in section 15.24.
- c. Whether the enrollment changes were received in an enrollment application that was processed to completion within 90 days of when the change of enrollment occurred.

Consider the following example:

Dr. Happy has reassigned his benefits to physician group Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on April 15, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal to the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 90 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 90 days of the change of enrollment information. Though an application was received within 90 days of the change of enrollment information, that application was not processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

- 3) For deactivations under 42 C. F. R. 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and

supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following.

- a. Whether the deactivation was implemented after 90 days of the revalidation request.
- b. Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 15.24.
- c. Whether a revalidation application was timely received that was processed to completion.

Consider the following example:

On January 1, 2018, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2018. The contractor receives a revalidation application from Dr. Great on March 1, 2018. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2018 revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 2018. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Therefore, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contractor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submission shall be sent via hard-copy mail to the return address on the rebuttal submission and by email, if a valid email address is available. The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

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

remain deactivated until a reactivation application is received and processed to completion.

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

#### **D. Rebuttal Determination is Not Subject to Further Review**

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

### **15.27.5.2 – Rebuttal Model Letters**

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

#### **A. Instruction**

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

#### **B. Rebuttal Signature Development Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required in the Medicare Program Integrity Manual, Ch. 15, Section 15.27.5.1. [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)



[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

**C. Rebuttal Further Information Required Development Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD], [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May  
be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

#### **D. Rebuttal Moot Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

#### **E. Rebuttal Withdrawn Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

**F. Rebuttal Receipt Acknowledgement Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

## G. Final Rebuttal Decision Email Template

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

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

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

Dear [Name of the person(s) who submitted the rebuttal]:  
Please see the attached determination regarding your rebuttal.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May  
be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

## H. Rebuttal Dismissal Model Letters

### 1. Untimely

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address] (Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]  
PTAN: [XXXXXX]  
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within 20 calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

## 2. Improper Signature

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

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

**Subject:** Medicare Provider Enrollment Rebuttal re: [Provider/Supplier Name] [Month] [DD], [YYYY]

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

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within 20 calendar days of the date of the deactivation letter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

### 3. No Rebuttal Rights

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name].

[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May  
be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

#### **4. More than One Submission**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]



Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 15 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May  
be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

### **I. Rebuttal Not Actionable Model Letter (Moot)**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May  
be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

## **J. Favorable Rebuttal Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)(1-3)

**OTHER APPLICABLE AUTHORITIES:**

- 42 C.F.R. §
- Medicare Program Integrity Manual (MPIM) chapter 15.XX (If applicable).

**EXHIBITS:**

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

**BACKGROUND:**

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

**REBUTTAL ANALYSIS:**

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider’s or supplier’s Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

**DECISION:**

(A short conclusory restatement.)

**(Example:** On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC’s revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC’s Medicare billing privileges is not justified based on the information available.

This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]’s Medicare billing privileges.

**(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)**

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

**K. Unfavorable Rebuttal Model Letter**

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

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

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

**DEACTIVATION REASON:**

- 42 C.F.R. § 424.540(a)(1-3)

**OTHER APPLICABLE AUTHORITIES:**

- 42 C.F.R. §
- Medicare Program Integrity Manual chapter 15.XX (If applicable)

**EXHIBITS:**

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);

- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

### **BACKGROUND:**

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the rebuttal.]

### **REBUTTAL ANALYSIS:**

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

### **DECISION:**

(A short conclusory restatement.)

(**Example:** On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-3) is justified.)

This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].

Sincerely,

[Signature of Hearing Officer] (May  
be electronic)

[Name of Hearing Officer]  
[Position of Hearing Officer]  
[MAC Name]

### **15.27.5.3 – Rebuttal Reporting Requirements**

**(Rev. 904, Issued: 09- 27-19, Effective: 12-31-19; Implementation: 12-31-19)**

#### **A. Monthly**

Using the rebuttal reporting template, the contractor shall complete all columns listed for all rebuttal submissions. No column should be left blank.

The response in the column labelled “Final Decision Result” should be one of the following:

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved.
- **Favorable (to provider/supplier):** MAC has determined that an error was made in the implementation of the deactivation. Therefore, the deactivation was not justified and the enrollment record has been placed back into an approved status.
- **Unfavorable (to provider/supplier):** MAC has determined that the deactivation was justified and the enrollment record remains deactivated.
- **Dismissed:** The appeal does not meet the rebuttal submission requirements. (Ex: incorrect signature, untimely, not rebuttable, etc.)
- **Rescinded:** MAC has received instruction from CMS to rescind the deactivation and return the enrollment record to an approved status.
- **Withdrawn:** Provider/supplier has submitted written notice of its intent to withdraw its rebuttal.

The reports shall be sent to CMS via email at [ProviderEnrollmentAppeals@cms.hhs.gov](mailto:ProviderEnrollmentAppeals@cms.hhs.gov) no later than the 15<sup>th</sup> of each month; the report shall cover the prior month’s rebuttal submissions (e.g., the February report shall cover all January rebuttals). If this day falls on a weekend or a holiday, the report must be submitted the following business day.

### **15.29.11 – Revalidation Extension Requests**

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

MACs shall only accept extension requests from a provider or supplier that was not given the full seven months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. MACs shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the MAC shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. MACs shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.



## Transmittals Issued for this Chapter

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<u>R10723PI</u>	04/08/2021	Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08	08/10/2020	11551
<u>R10383PI</u>	10/09/2020	Updates to Chapters 4, 5, 8, 15, and Exhibits of Publication (Pub.) 100-08	11/10/2020	11999
<u>R10353PI</u>	09/11/2020	Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10 of Pub. 100-08, Modification of the Timeliness Standards	02/01/2021	11865
<u>R10345PI</u>	09/11/2020	Chapter 15 of Publication (Pub.) 100-08 Manual Redesign – Additional Release of Chapter 10	11/13/2020	11700
<u>R10239PI</u>	07/28/2020	Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08- Rescinded and replaced by Transmittal 10723	08/10/2020	11551
<u>R10182PI</u>	06/15/2020	Update to Chapter 10 of Publication (Pub.) 100-08 - Model Letter Templates	09/16/2020	11375
<u>R10146PI</u>	05/22/2020	Implementation of Provider Enrollment Provisions in CMS-6058-FC – Phase 1 – Continued Removal/Moving of Instructions from Chapter 15 of Publication (Pub.) 100-08 to Chapter 10 of Pub. 100-08- Rescinded and replaced by Transmittal 10239	07/24/2020	11551
<u>R10138PI</u>	05/15/2020	Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment)	06/16/2020	11546
	11/22/2019	Additional Guidance on Private Contracting/Opting-out of Medicare and	12/24/2019	10939

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
		Entering Opt-out Affidavit Records in the Provider Enrollment, Chain and Ownership System (PECOS)		
<u>R904PI</u>	09/27/2019	Provider Enrollment Rebuttal Process	12/31/2019	10978
<u>R902PI</u>	09/27/2019	Updates to Chapters 3, 4, 8, 15, and Exhibits of Publication (Pub.) 100-08	10/28/2019	11425
<u>R898PI</u>	09/06/2019	Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08, Program Integrity Manual, and to the CMS-855R Processing Guide	10/07/2019	11371
<u>R896PI</u>	08/30/2019	Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08	10/01/2019	11325
<u>R882PI</u>	05/24/2019	Additional Processing Procedure for Adding a New Provider-Based Location for Critical Access Hospitals (CAHs)	06/25/2019	11246
<u>R865PI</u>	02/21/2019	Update to Chapter 15 of Publication (Pub.) 100-08	03/12/2019	10954
<u>R862PI</u>	02/08/2019	Update to Chapter 15 of Publication (Pub.) 100-08- Rescinded and replaced by Transmittal 865	03/12/2019	10954
<u>R824PI</u>	09/05/2018	Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies	10/01/2018	10845
<u>R822PI</u>	08/24/2018	Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies- Rescinded and replaced by Transmittal 824	10/01/2018	10845
<u>R797PI</u>	06/01/2018	Reviewing for Adverse Legal Actions (ALA)	04/30/2018	10558
<u>R762PI</u>	04/30/2017	Update to Chapter 15 of Pub. 100-08	01/29/2018	10386
<u>R782PI</u>	03/30/2018	Update to Chapter 15 of Publication 100-08 - Medicare Enrollment Deactivation Policies	04/30/2018	10443

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<u>R784PI</u>	03/30/2018	Reviewing for Adverse Legal Actions (ALA)	04/30/2018	10558
<u>R773PI</u>	02/23/2018	Form CMS-855O Processing Guide	03/23/2018	10355
<u>R765PI</u>	01/08/2018	Medicare Diabetes Prevention Program (MDPP) Enrollment Process	01/19/2018	10356
<u>R734PI</u>	07/28/2017	Update to Reporting Requirements	06/27/2017	9924
<u>R719PI</u>	05/26/2017	Update to Reporting Requirements	06/27/2017	9924
<u>R718PI</u>	05/19/2017	Reviewing for Adverse Legal Actions (ALA)	06/20/2017	9879
<u>R717PI</u>	05/12/2017	Update to Pub. 100-08, Chapter 15	05/15/2017	9953
<u>R715PI</u>	05/11/2017	Update to Pub. 100-08, Chapter 15	06/13/2017	9953
<u>R711PI</u>	04/25/2017	Update to Pub. 100-08, Chapter 15	05/15/2017	9953
<u>R710PI</u>	04/14/2017	Update to Pub. 100-08, Chapter 15	05/15/2017	9953
<u>R689PI</u>	12/09/2016	Clarification of Certification Statement Signature and Contact Person Requirements	01/09/2017	9776
<u>R688PI</u>	11/18/2016	Update to Pub. 100-08, Chapter 15	07/26/2016	9635
<u>R685PI</u>	11/03/2016	Incorporation of Cycle 2 Revalidation Policies	09/06/2016	9628
<u>R684PI</u>	11/01/2016	Incorporation of Cycle 2 Revalidation Policies – Rescinded and replaced by Transmittal 685	12/02/2016	9628
<u>R681PI</u>	10/27/2016	Revision to Surety Bond Collection Procedures	01/30/2017	9755
<u>R676PI</u>	09/16/2016	Clarification of Certain Policies in Pub. 100-08, Chapter 15 Regarding the Processing of Form CMS-855R Applications	12/19/2016	9552
<u>R666PI</u>	08/05/2016	Incorporation of Cycle 2 Revalidation Policies - Rescinded and replaced by Transmittal 684	09/06/2016	9628
<u>R659PI</u>	06/24/2016	Update to Pub. 100-08, Chapter 15 - Rescinded and replaced by Transmittal 688	07/26/2016	9635
<u>R636PI</u>	02/04/2016	Update to Pub. 100-08, Chapter 15	03/04/2016	9390
<u>R626PI</u>	11/13/2015	Update to Surety Bond Collection Requirements	12/14/2015	9296
<u>R609PI</u>	08/14/2015	Clarification Regarding the Processing of	11/02/2015	9174

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		Certain Provider Enrollment-Related Transactions		
<u>R605PI</u>	07/31/2015	Clarification Regarding the Processing of Certain Provider Enrollment-Related Transactions – Rescinded and replaced by Transmittal 609	11/02/2015	9174
<u>R592PI</u>	05/08/2015	Update of Provider Enrollment Instructions in Chapter 15 of Pub. 100-08	06/08/2015	9139
<u>R591PI</u>	05/08/2015	Revisions to Surety Bond Collection Policies	06/08/2015	9123
<u>R590PI</u>	04/24/2015	Update of CMS-855A, Physician-Owned Hospital Reporting Via the CMS-855POH and Indirect Payment Procedure Registration Via the CMS-855C in Chapter 15 of Pub. 100-08	05/25/2015	9120
<u>R587PI</u>	04/17/2015	Clarification of Ordering and Certifying Documentation Maintenance Requirements	07/20/2015	9112
<u>R582PI</u>	03/04/2015	Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	05/28/2015	9065
<u>R581PI</u>	02/27/2015	Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 – Rescinded and replaced by Transmittal 582	05/28/2015	9065
<u>R578PI</u>	02/25/2015	Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	05/15/2015	9011
<u>R575PI</u>	02/13/2015	Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 – Rescinded and replaced by Transmittal 578	05/15/2015	9011
<u>R561PI</u>	12/12/2014	Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	04/18/2015	8901
<u>R556PI</u>	11/26/2014	Revisions to Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	12/29/2014	8810
<u>R539PI</u>	08/29/2014	Cardiac Rehabilitation Programs for	08/18/2014	8758

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		Chronic Heart Failure – Rescinded and replaced with Transmittal 539		
<u>R532PI</u>	08/01/2014	Incorporation of Various Form CMS-855 Processing Activities into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	09/02/2014	8842
<u>R530PI</u>	07/18/2014	Cardiac Rehabilitation Programs for Chronic Heart Failure – Rescinded and replaced with Transmittal 539	08/18/2014	8758
R525PI	06/27/2014	Update to Form CMS-855 Application Processing Sections of CMS Pub. 100-08, Chapter 15	07/29/2014	8637
R521PI	06/13/2014	Submission of Community Mental Health Center (CMHC) Certifications of Compliance with Section 485.918(b)(1)	07/15/2014	8784
R519PI	05/30/2014	Revision to CMS Publication 100-08, Chapter 15	07/31/2014	8512
R517PI	05/16/2014	Update to Surety Bond Collection Procedures	06/17/2014	8636
R514PI	05/02/2014	Update to CMS Publication 100-08, Chapter 15	06/03/2014	8682
R509PI	03/27/2014	Change in Provider Enrollment Timeliness Standards	06/02/2014	8551
R507PI	02/28/2014	Change in Provider Enrollment Timeliness Standards – Rescinded and replaced by Transmittal 509	05/29/2014	8551
R503PI	01/24/2014	Inter-Jurisdictional Reassignments	02/25/2014	8545
R502PI	01/17/2014	Registration of Entities Using the Indirect Payment Procedure (IPP)	01/06/14	8284
R499PI	12/27/2013	Update to Chapter 15 of the Program Integrity Manual	01/28/2014	8544
R494PI	12/06/2013	Registration of Entities Using the Indirect Payment Procedure (IPP)	01/06/14	8284
R492PI	12/06/2013	Additional Updates to Chapter 15 of the Program Integrity Manual (PIM)	01/07/2014	8393
R490PI	11/06/2013	Reassignment to Part A Critical Access Hospitals Billing Under Method II (CAH II)	01/06/2014	8387
R483PI	08/16/2013	Reassignment to Part A Critical Access	01/06/2014	8387

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		Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) – Rescinded and replaced by Transmittal 490		
R479PI	08/01/2013	Enrollment Denials When an Existing or Delinquent Overpayment Exists	10/07/2013	8039
R478PI	08/02/2013	Registration of Entities Using the Indirect Payment Procedure (IPP) – Rescinded and replaced by Transmittal 494	01/06/2014	8284
R474PI	07/05/2013	Update to Chapter 15 of the Program Integrity Manual (PIM)	10/08/2013	8341
R471PI	06/11/2013	Update to Chapter 15 of the Program Integrity Manual (PIM)	05/28/2013	8222
R470PI	05/31/2013	Revision to Surety Bond Collection Process	07/01/2013	8283
R469PI	05/31/2013	Enrollment Denials When an Existing or Delinquent Overpayment Exists – Rescinded and replaced by Transmittal 479	10/07/2013	8039
R463PI	05/17/2013	Model Letter Revisions	06/07/2013	8117
R462PI	05/16/2013	Update to Chapter 15 of the Program Integrity Manual (PIM)	03/18/2013	8155
R461PI	04/26/2013	Update to Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 471	05/28/2013	8222
R459PI	04/12/2013	Tax Identification Numbers of Foreign Owning and Managing Entities and Individuals	05/13/2013	8258
R457PI	04/02/2013	Model Letter Revisions – Rescinded and replaced by Transmittal 463	04/22/2013	8117
R456PI	03/22/2013	Model Letter Revisions – Rescinded and replaced by Transmittal 457	04/22/2013	8117
R450PI	02/15/2013	Update to Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 462	03/18/2013	8155
R445PI	12/14/2012	Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM)	01/01/2014	7864
R440PI	11/23/2012	Revisions to Appeals Section of Chapter 15 of the Program Integrity Manual (PIM)	12/24/2012	8110

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R437PI	11/02/2012	Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM) – Rescinded and replaced by Transmittal 445	02/01/2013	7864
R435PI	10/19/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part IX	11/20/2012	8019
R433PI	09/07/2012	Review of Debarment List and Processing of Tie-in Notices	10/09/2012	8020
R431PI	08/31/2012	Ordering and Certifying Documentation-Maintenance Requirements	10/01/2012	7890
R430PI	09/28/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VIII	10/29/2012	7889
R424PI	06/13/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VI	06/19/2012	7827
R423PI	06/01/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VII	07/02/2012	7839
R421PI	05/18/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part VI – Rescinded and replaced by Transmittal 424	06/19/2012	7827
R416PI	04/13/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part III	02/27/2012	7698
R415PI	04/13/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part V	05/14/2012	7797
R414PI	04/06/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part IV	05/07/2012	7763
R412PI	03/30/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part II	04/30/2012	7646
R410PI	03/02/2012	Instructions for Processing Form CMS-8550 Submissions	06/04/2012	7723
R408PI	02/22/2012	Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators	02/03/2012	7363
R407PI	02/09/2012	Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures(This CR Fully Rescinds and Replaces CR 7177)	01/27/2012	7681
R405PI	01/26/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM) –Part III	02/27/2012	7698

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		– Rescinded and replaced by Transmittal 416		
R404PI	01/20/2012	General Update to Chapter 15 of the Program Integrity Manual (PIM)-Part I	04/22/2012	7579
R403PI	01/20/2012	Claims Against Surety Bonds for Suppliers of Durable Medicare Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	02/21/2012	7167
R402PI	01/13/2012	Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures(This CR Fully Rescinds and Replaces CR 7177) – Rescinded and replaced by Transmittal 407	01/27/2012	7681
R400PI	11/21/2011	Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 408	02/03/2012	7363
R394PI	10/27/2011	Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators – Rescinded and replaced by Transmittal 400	02/03/2012	7363
R392PI	10/14/2011	Update to Notifications Sent to State Medicaid Agencies and Child Health Plans of Medicare Terminations for Certified Providers and Suppliers and Medicare Revocations for Providers and Suppliers. This CR rescinds and fully replaces CR 7017, 7074 and 7334	11/15/2011	7532
R388PI	09/16/2011	Additional Review Activities for Home Health Agencies (HHAs)	12/17/2011	7525
R387PI	09/01/2011	Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare Beneficiaries	10/18/2010	7097
R380PI	08/03/2011	Advanced Diagnostic Imaging Accreditation Enrollment Procedures	07/05/2011	7177
R374PI	05/06/2011	Update to Notifications Sent to State Medicaid Agencies and Child Health	06/06/2011	7334



<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
		Plans of Medicare Terminations for Certified Providers and Suppliers and Medicare Revocations for Providers and Suppliers		
R373PI	04/07/2011	Advanced Diagnostic Imaging Accreditation Enrollment Procedures – Rescinded and replaced by Transmittal 380	07/05/2011	7177
R372PI	03/25/2011	Effective Date of Certified Provider or Supplier Agreement or Approval	04/25/2011	7232
R371PI	03/23/2011	Implementation of Provider Enrollment Provisions in CMS-6028-FC	03/25/2011	7350
R369PI	03/11/2011	Advanced Diagnostic Imaging Accreditation Enrollment Procedures – Rescinded and replaced by Transmittal 373	06/12/2011	7177
R365PI	01/28/2011	Diabetes Self-Management Training (DSMT)	04/29/2011	7236
R363PI	01/14/2011	Clarification for Part A Contractors Including Audit and Claims Intermediaries Notifying Each Other via E-mail Upon Processing of the Initial Enrollment Application, Change of Information, Voluntary Termination, or Any Other CMS-855 Transaction	02/15/2011	7221
R358PI	10/29/2010	Indian Health Service (IHS) Facilities and Tribal Provider’s Use of Internet-based Provider Enrollment, Chain and Ownership System (PECOS)	11/29/2010	7174
R357PI	10/01/2010	Durable Medical Equipment (DME MAC) and the National Supplier Clearinghouse (NSC MAC) Procedures for Third Party Notification of Deceased Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Supplier Associates	10/04/2010	6714
R356PI	09/24/2010	Manual Redesign	10/26/2010	7083
R355PI	09/17/2010	Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare	10/18/2010	7097

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
		Beneficiaries		
R354PI	08/27/2010	Manual Redesign	09/28/2010	7016
R353PI	08/27/2010	Notification to State Medicaid Agencies and Child Health Plans of Medicare Terminations for Certified Providers and Suppliers	09/28/2010	7074
R350PI	08/20/2010	Notification to State Medicaid Agencies and Child Health plans of Medicare Revocation	09/21/2010	7017
R347PI	07/15/2010	Chapter 10 Manual Redesign - Initial release of Chapter 15	07/30/2010	6938
R346PI	06/25/2010	Guidance on Implementing Section 3109 of the Patient Protection and Affordable Care Act (PPACA)	01/03/2011	7021
R344PI	06/18/2010	Chapter 10 Manual Redesign - Initial release of Chapter 15 - Rescinded and replaced by Transmittal 347	07/05/2011	6938

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