| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 865** | **Date: February 21, 2019** |
| | **Change Request 10954** |

**Transmittal 862, February 8, 2019, is being rescinded and replaced by Transmittal 865, dated, February 21, 2019, to remove the MLN article requirement, to remove the new section 15.30, and remove the change to the table of contents. All other information remains the same.**

**SUBJECT: Update to Chapter 15 of Publication (Pub.) 100-08**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to make several changes to provider enrollment policies. The changes to Chapter 15 of Pub. 100-08 include updates to--1) Final Adverse Action policies; 2) Establishment of Effective Date of Medicare Billing Privileges and Retrospective Billing dates; 3) Application Processing alternatives; and 4) Revalidation Application Return policies.

**EFFECTIVE DATE: March 12, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: March 12, 2019**

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 15/15.5/15.5.3/Final Adverse Actions |
| R | 15/15.5/15.5.3.1/Reviewing for Final Adverse Actions |
| R | 15/15.7/15.7.1.3.1/Processing Alternatives – Form CMS-855B and Form CMS-855I |
| R | 15/15.7/15.7.1.3.2/Processing Alternatives – Form CMS-855A |
| R | 15/15.7/15.7.1.3.3/Processing Alternatives – Form CMS-855O |
| R | 15/15.7/15.7.1.3.5/Processing Alternatives – Form CMS-20134 |
| R | 15/15.8/15.8.1/Returns |
| R | 15/15.17/Establishing an Effective Date of Medicare Billing Privileges |
| R | 15/15.24/15.24.5.2/Model Large Group Revalidation Notification Letter |
| R | 15/15.24/15.24.5.7/Model Return Revalidation Letter |
| R | 15/15.27/15.27.1.1/Deactivations |
| R | 15/15.27/15.27.1.2/Reactivations |
| R | 15/15.29/15.29.4/Receipt of Revalidation Application |
| R | 15/15.29/15.29.4.1/Revalidation Application Received and Development Required |
| R | 15/15.29/15.29.4.3/Revalidation Received After a Deactivation Occurs |
| R | 15/15.29/15.29.4.5/Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed |
| R | 15/15.29/15.29.7/Large Group Revalidation Coordination |

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-08 | Transmittal: 865 | Date: February 21, 2019 | Change Request: 10954 |
|---|---|---|---|

**Transmittal 862, February 8, 2019, is being rescinded and replaced by Transmittal 865 dated February 21, 2019, to remove the MLN article requirement, to remove the new section 15.30, and remove the change to the table of contents. All other information remains the same.**

**SUBJECT: Update to Chapter 15 of Publication (Pub.) 100-08**

**EFFECTIVE DATE: March 12, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: March 12, 2019**

## I. GENERAL INFORMATION

**A. Background:** This CR will adjust the revalidation application return timeframe from 6 months to 7 months. In addition, this CR allows for additional application processing alternatives, makes several small additions to the final adverse action section, and adjusts the applicability of the retrospective billing date.

**B. Policy:** There is no legislative or regulatory impact associated with this CR.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 10954.1 | Contractors shall return an application if the provider or supplier submitted a revalidation application more than seven months prior to their revalidation due date. | X | X | X | | | | | | |
| 10954.2 | If the supporting documentation | X | X | X | | | | | | NSC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment | | | | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | application processing or vice-versa. | | | | | | | | | |
| 10954.2.1 | The contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. | X | X | X | | | | | | NSC |
| 10954.3 | Contractors shall be aware that the Medicare Diabetes Prevention Program business requirements and manual update have been removed from this change request (CR). | X | X | X | | | | | | |
| 10954.4 | Contractors shall grant retrospective billing privileges in accordance with Section 15.17(B) of Chapter 15 in Pub. 100-08 for the initially enrolling and reactivating providers and suppliers, unless otherwise stated. This includes providers that were | X | X | X | | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| | deactivated for not responding to a revalidation request. | | | | | | | | | |
| 10954.5 | Contractors shall grant effective dates for occupational therapists and physical therapists in accordance with 42 CFR §424.520(d). | | X | | | | | | | |
| 10954.6 | Contractors shall be aware that the Section 15.24.7 (Approval Letter Guidance) has been removed from this CR. | X | X | X | | | | | | NSC |
| 10954.7 | Contractors shall be aware that several small revisions were made to Section 15.5.3 (Final Adverse Actions) to include civil monetary penalties and corporate integrity agreements as examples of reportable adverse legal actions, since they are reportable federal sanctions. | X | X | X | | | | | | NSC |
| 10954.8 | Contractors shall be aware that references to | X | X | X | | | | | | NSC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | *monetary penalties* have been removed from Section 15.5.3.1 (Reviewing for Adverse Legal Actions). | | | | | | | | | |
| 10954.9 | Contractors shall not require the provider to enter the phone in Section 15 (Form CMS-855I) or Section 15 and 16 (Form CMS-855B). | | X | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

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

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Joseph Schultz, 410-786-2656 or Joseph.Schultz@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

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

**ATTACHMENTS: 0**

## 15.5.3 – Final Adverse Actions

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

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

### A. Disclosure of Final Adverse Action

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

In addition:

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

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

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

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

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

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

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

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

**B. Reportable Final Adverse Actions**

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

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

1. Felony conviction(s) within 10 years

    - Providers are required to report a felony (Federal or State) when--

        - A conviction has occurred; and

        - The felony judgment (disposition) date is within 10 years, from the submission date of an Form CMS-855 or Form CMS-20134 application.

    - A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.

    - A felony conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

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

        - A conviction has occurred; and

- The misdemeanor judgment (disposition) date is within 10 years, from the submission date of an Form CMS-855 or Form CMS-20134 application, and

- The misdemeanor is related to:

    - The delivery of an item/service under Medicare or a State health care item/service

    - *The abuse or neglect of a patient in connection with the delivery of a health care item or service*

    - Theft, Fraud, Embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health care item/service

    - The interference *with* or obstruction of any investigation into any criminal offense

    - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance

- A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.

- A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

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

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

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

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

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

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

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

    - An individual or entity is suspended throughout the Executive Branch or the Federal government, as it applies to procurement and non-procurement programs. An individual

or entity will not be solicited from, contracts will not be awarded to or existing contracts will not be renewed or otherwise extended to those individuals or entities with a debarment. (e.g. GSA debarment)

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

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

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

**C. Prior Approval**

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

**D. Review of PECOS**

If the contractor denies an application or revokes a provider based on a final adverse action, the contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal system) to determine:

- Whether the person/entity with the *final* adverse action has any other associations, as it applies (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers).

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

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

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

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

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

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

## 15.5.3.1 – Reviewing for Adverse Legal Actions

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

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

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

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

### I. *INITIAL/ REACTIVATION APPLICATIONS*

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

### 1.1 LICENSURE – INITIAL/REACTIVATION APPLICATIONS

| **Provider holds a valid accreditation/medical license in the state in which they are enrolling** | **Did the provider report the ALA taken on their license/ accreditation?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Provider's accreditation/medical license was previously suspended / revoked / voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | Yes | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.2 – 1.*8*. | MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/revocation. e.g. Felonies. |
| Provider's accreditation/medical license was previously suspended/revoked/ voluntarily surrendered while formal disciplinary proceeding was pending before a State licensing authority. | No | Deny application under 42 CFR § 424.530 (a)(4) unless the license adverse action occurred more than ten years prior to the date of application receipt. If a license suspension/revocation /surrender in lieu of disciplinary proceedings occurred more than ten years prior to the date of application receipt, the application and ALA information shall be sent to EnrollmentReview@cms.hhs.go v for review anddecision. | 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action.<br><br>MACs shall consider whether other denial reasons exist. Refer to section (s) 1.2 – 1.*8*.<br><br>MACs shall read board orders thoroughly to determine if there are other adverse actions associated with the license suspension/ revocation. e.g. Felonies<br><br>No Reporting Requirement:<br><br>• A suspension is "stayed" inits entirety.<br><br>• Advertising/Administrative penal-ties<br><br>• Fines, Violations,Stipulations, Reprimands |

## 1.2 FELONIES – INITIAL/REACTIVATION APPLICATIONS

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

## 1.2 MISDEMEANORS – INITIAL/REACTIVATION APPLICATIONS

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

## 1.3 EXCLUSION (ACTIVE) – INITIAL/REACTIVATION APPLICATIONS

| **Current Exclusion** | **Did the provider report their current exclusion?** | **MAC Action** | **Notes** |
|---|---|---|---|
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | Yes | Deny application under 42 CFR § 424.530 (a)(2) | MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.2 & 1.4 - 1.*8*.<br><br>A waiver does not guarantee automatic enrollment into the Medicare program. All waivers shall be sent to Enroll-mentReview@cms.hhs.gov for review. |
| Provider or someone with ownership interest and/or managing control has an active HHS and/or OIG exclusion | No | Deny application under 42 CFR § 424.530 (a)(2) & (a)(4) | 42 CFR § 424.530 (a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action. However § 424.530 (a)(2), in this particular scenario, would still be apply. |

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

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

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

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

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

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

## 1.7 MEDICARE REVOCATION – INITIAL/REACTIVATION APPLICATIONS

| **Medicare Revocation** | **Did the provider report their Medicare Revocation?** | **MAC Action** | **Notes** |
|---|---|---|---|
| All prior enrollment bar(s) have expired | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 1.1 – 1.6, *1.8*. | Providers are NOT required to report Current or Past Medicare Revocations to CMS.<br><br>MACs shall consider whether other denial reasons exist. Refer to section(s) 1.1 – 1.6, 1.*8*. |
| Enrollment bar is active in the state that the provider is enrolling | Yes or No | Return the application | |
| Enrollment bar is active in a state other than the enrolling state | Yes or no | Return the application. | |

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

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

## *II. REVALIDATIONS/CHANGE OF INFORMATION APPLICATIONS*

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

## 2.1 LICENSURE – REVALIDATIONS/ CHANGE OF INFORMATION APPLICATIONS

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

## 2.2 FELONIES — REVALIDATION/ CHANGE OF INFORMATION APPLICATIONS

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

## 2.2 MISDEMEANORS – REVALIDATION/ CHANGE OF INFORMATION APPLICATION

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

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

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

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

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

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

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

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

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

| 2.7 MEDICARE REVOCATION – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS | | | |
|---|---|---|---|
| **Any Medicare** | **Did the provider report their Medicare** | **MAC Action** | **Notes** |
| All prior enrollment bar(s) have expired | Yes or No | Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.6, *2.8*. | Providers are NOT required to report Current or Past Medicare Revocations to CMS.<br><br>MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.6, *2.8*. |
| Enrollment bar is active in state other than the current state | Yes or No | Process the application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.6, *2.8* | Providers are NOT required to report Current or Past Medicare Revocations to CMS.<br><br>MACs shall consider whether other revocation reasons exist. Refer to section(s) 2.1 – 2.6, *2.8*. |

| *2.8 FEDERAL SANCTION (CIVIL MONETARY PENALTY OR CORPORATE INTEGRITY AGREEMENT) – REVALIDATION/CHANGE OF INFORMATION APPLICATIONS* | | | |
|---|---|---|---|
| ***Federal Sanction*** | ***Did the provider report their Federal Sanction?*** | ***MAC Action*** | ***Notes*** |
| *The provider has a current or past federal sanction* | *Yes* | *Process application unless there is another reported adverse legal action that precludes the processing of the application. Refer to section(s) 2.1 – 2.7.* | |
| *The provider has a current or past federal sanction* | *No* | *MACs are only required to verify via SAM/OIG checks whether a provider has a CMP/CIA. If encountered here or otherwise, MAC shall send the application and ALA information to EnrollmentReview@cms.hhs.gov for review and decision.* | *MACs shall consider whether other denial reasons exist. Refer to section(s) 2.1 – 2.7.* |

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

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

### A. General Processing Alternatives

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

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

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

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

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

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

2. Licenses

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

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

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

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

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

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

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

**B. Sectional Processing Alternatives**

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

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

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

2. Section 2

a. Form CMS-855B

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

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

b. Form CMS-855I

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

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

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

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

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

3. Section 4

a. Form CMS-855B

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

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

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-855.

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

b. Form CMS-855I

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

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

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

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

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

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

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

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

the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

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

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

7. Attachment 1 (Form CMS-855B)

In section D, the "Land," "Air," and "Marine" boxes need not be checked (or developed) if the type of vehicle involved is clear.

8. Attachment 2 (Form CMS-855B)

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

***C. Supporting Documents***

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

## 15.7.1.3.2 – Processing Alternatives – Form CMS-855A

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

### A. General Processing Alternatives

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

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

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

b. All legal business names (LBNs)(e.g., provider, chain home office)
Note: If an application is submitted with a valid NPI and OSCAR combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855A and the contractor is able to confirm the correct LBN based on the NPI and OSCAR combination provided, the contractor is not required to develop.

c. All tax identification numbers (TINs)(e.g., provider, owning organization)

d. NPI-legacy number combinations in section 4 of the Form CMS-855A
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

e. Provider type

f. The following data in sections 2F, 2G and 2H:

- "Doing business as" name
- Effective dates of sale/transfer/consolidation
- Checkbox in section 2F indicating whether seller will accept assets/liabilities
- Names of units with separate legacy numbers/NPIs;
- All NPIs and legacy numbers
  Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the OSCAR or NPI before developing to the provider.

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

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

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, or certifications. It does not apply to items such as adverse action documentation, bills of sale, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed.

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

**B. Sectional Processing Alternatives**

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

1. Section 1

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

2. Section 2

- Other than the TIN and the LBN, all information in section 2B1 can be captured by telephone, email, fax, or a Web site.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes in section 2B2 are not checked, no further development is needed.

- With respect to sections 2F, 2G, and 2H, if the old/new owner's current contractor is not listed, the contractor can research this data on its own or obtain it from the provider by any means.

3. Section 4

- In section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via email or fax.

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

- In section 4D, if the "Check here" box is not checked and no address is provided, the contractor can contact the provider by telephone, email or fax to confirm the provider's intentions. If the provider replies that the base of operations address is the same as the practice location, no further development is needed. If the provider indicates that the base of operations is at a different location, the address in 4D must be completed via the Form CMS-855A.

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

4. Section 7

- If all of section 7 is blank (including the check box just above section 7A), no additional development is necessary.

- If the provider indicates that it is part of a chain but the checkboxes in section 7A are blank, the contractor can verify the type of transaction involved via email or fax.

- In section 7B, if the person is also listed with complete information in section 6A (e.g., the individual's Social Security Number (SSN) is listed in section 6A1), only the individual's first and last name need be listed in section 7B.

- In section 7C, if the entity is also listed with complete information in section 5A, the company's legal business name is the only data that must be listed in section 7C. (If blank, the cost report date, the home office's contractor, and the chain number can be developed by phone, email, or fax.)

- If blank, data in section 7D can be collected by telephone, email or fax.

- If blank, data in section 7E can be collected by email or fax.

5. Section 8

- If the telephone number is blank, the number can be verified with the provider by telephone, email or fax.

- If all of section 8 is blank (including the check box), no additional development is necessary.

6. Section 12

- If it is obvious that the entity is not enrolling as a home health agency (HHA), the checkbox above section 12A can be left blank.

- If the entity is an HHA:

  - If section 12A1 or 12A3B is blank, the data can be verified by telephone, email, or fax.

  - If the telephone number in section 12B is blank, the number can be verified with the provider by telephone, email or fax.

7. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor may either (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.

- Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

8. Sections 15 and 16

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

***C. Supporting Documents***

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

## 15.7.1.3.3 – Processing Alternatives – Form CMS-855O

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

### A. General Processing Alternatives

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

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

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

2. Licenses

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

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

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees such as adverse action documentation. Furthermore, the exception is moot in cases where a particular license/certification is not required by the state.

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

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

**B. Sectional Processing Alternatives**

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

1. Section 1

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

2. Section 2

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

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

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

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

3. Section 4

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

4. Section 6

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

***C. Supporting Documents***

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

## 15.7.1.3.5 - Processing Alternatives – Form CMS-20134

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

### A. General Processing

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

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

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

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

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

c. Tax identification numbers (TIN)

d. NPI-legacy number combinations in Section 4 of the Form CMS-20134
   Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

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

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

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

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

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

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

**B. Sectional Processing Alternatives**

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

1. Section 1

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

2. Section 2

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

3. Section 4

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

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the administrative location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-20134.

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-20134.

4. Section 7

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

5. Section 8

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

6. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

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

- Currently there is no option on the CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the Form CMS-20134.

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

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

***C. Supporting Documents***

*If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or*

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

## 15.8.1 – Returns

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

### A. Reasons for Return

Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the National Supplier Clearinghouse) may immediately return the enrollment application to the provider or supplier only in the instances described below. This policy – again, unless stated otherwise in this chapter or in another CMS directive - applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations):

- The applicant sent its paper Form CMS-855 or Form CMS-20134 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).

- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSs), or MDPP supplier application submissions received between January 1, 2018 and March 31, 2018).

- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.

- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.

- The application is not needed for the transaction in question. Two common examples include:

    - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

    - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.

- The provider or supplier submitted a revalidation application more than *seven* months prior to their revalidation due date.

- The MDPP supplier submitted an application with a coach start date more than 30 days in the future.

The contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a "rejected" application and a "returned" application is that the former is typically based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is effectively considered a non-application.

**B. Procedures for Returning the Application**

If the contractor returns the application:

- It shall notify the provider via letter (sent by mail or e-mail) that the application is being returned, the reason(s) for the return, and how to reapply.
- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

If the contractor returns an application, it shall (1) keep the original application and supporting documents and return a copy, (2) make a copy or scan of the application and documents and return the originals to the provider, or (3) simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why. If the contractor chooses the third approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

**C. Other Impacts of a Return**

**1. Changes of Information and Changes of Ownership (CHOWs)**

a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Return, Rejection, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 15.8.2 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

**2. Reactivations –** If the contractor returns a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

2. **Revalidations –** If the contractor returns a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) returns it again, (2) rejects it per section 15.8.2 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.

## 15.17 – Establishing an Effective Date of Medicare Billing Privileges

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

(This section *applies* to the following individuals and organizations: physicians; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, *physical therapists, occupational therapists*; physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above; and ambulance suppliers.)

### A. Background

In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above is the later of:

- The date the supplier filed an enrollment application that was subsequently approved, or
- The date the supplier first began furnishing services at a new practice location.

**NOTE**: The date of filing for Form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.

### B. Retrospective Billing

Consistent with 42 CFR §424.521(a), the individuals and organizations identified above may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements, and
- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements including state licensure) during the 30-day period before an application was submitted and no final adverse action, as identified in § 424.502, precluded enrollment. If a final

adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for a determination on this issue.

**C. Legal Distinction between Effective Date of Enrollment and Retrospective Billing Date**

The effective date of enrollment is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non- Medicare enrolled physician begins furnishing services at an office on March 1. She submits a paper Form CMS-855I initial enrollment application on May 1; the contractor receives the application on May 4. The application is approved on June 1. The physician's effective date of enrollment is May 4, which is the later of (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 4 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR § 424.521(a) are met.

Hence, the effective date entered into PECOS and the Multi-Carrier System will be April 4; claims submitted for services provided before April 4 will not be paid.

## 15.24.5.2 – 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]

## 15.24.5.7 – Model Return Revalidation Letter

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

## RETURN REVALIDATION

[Month dd, yyyy]

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

Dear [Provider/Supplier Name],

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

- The [form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
    - An unsolicited revalidation is one that is received more than *seven* months prior to the provider/suppliers due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.
    - To find the provider/suppliers revalidation due date, please go to http://go.cms.gov/MedicareRevalidation.
    - If you are not due for revalidation in the current six month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current six month period. This list with be updated monthly.

- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].

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

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

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-

Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

**If you need help**
Visit http://go.cms.gov/MedicareRevalidation, or
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

## 15.27.1.1 – Deactivations

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

### A. Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its CMS Provider Enrollment Business Function Lead (PEBFL) - deactivate a provider or supplier's entire enrollment record and Medicare billing privileges when:

- A provider or supplier fails to respond to a revalidation request;
- A provider or supplier fails to respond timely to a revalidation development request, or;
- A provider is enrolled in an approved status without an active reassignment or practice location for 90 days or longer.

The contractor shall not take deactivation actions unless specified in this chapter or other CMS directives.

### B. Regulations

- Per §424.540(a)(1), a provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;
- Per §424.540(a)(2), a provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; a provider or supplier fails to report a change in ownership or control within 30 calendar days.
- Per §424.540(a)(3), a provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

### C. Effective Dates

The effective dates of a deactivation are as follows:

1. Non-Billing §424.540(a)(1) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.

2. Failure to Report or Furnish Information §424.540(a)(2) and (3), – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.

3. The "36-Month Rule" for HHAs – CMS' provider enrollment staff will determine the effective date during its review of the case.

**D. Appeals Rights**

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is made.

**E. Miscellaneous**

1. The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

2. Prior to deactivating an HHA's billing privileges for any reason (including under the "36-month rule"), the contractor shall refer the matter to its PEBFL for review and approval. The only exception for PEBFL review and approval is deactivations due to failure to comply with a revalidation request.

## 15.27.1.2 – Reactivations

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

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

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

*Contractors shall grant retrospective billing privileges in accordance with Section 15.17(B) for reactivating providers and suppliers, unless otherwise stated in this chapter. This includes providers that were deactivated for not responding to a revalidation request.*

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

## 15.29.4 - Receipt of Revalidation Application

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

MACs shall return all unsolicited applications. Unsolicited applications are: (1) revalidation applications received more than *seven* months prior to the provider/suppliers established due date and/or (2) Providers and suppliers identified as TBD (To Be Determined) on the revalidation look up tool. MACs shall return these applications using the sample return letter template provided in Pub. 100-08, chapter 15, section 15.24.5, within 20 business days of receipt. MACs shall also submit a request to CMS to have the application fee returned to the provider. Revalidation applications submitted within *seven* months of their due date shall be accepted and processed by the MAC. The submission date of a revalidation application for providers/suppliers who are on the CMS posted list will not alter their future revalidation due date.

The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization.

If a provider/supplier wishes to voluntary withdrawal from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail or fax from the individual provider or the AO/DO (on letterhead); the contractor shall not require the provider/supplier to complete a CMS-855 application. If the request is made via telephone, the contractor shall document the telephone conversation (in accordance with section 15.7.3 of this chapter) and take the appropriate action in PECOS.

Any subunit that has a separate provider agreement (e.g., home health agency (HHA) subunits) it must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the subunit has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the revalidation can be disclosed on the main provider's Form CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity. Separate fees are not required.

If the provider/supplier requests to collapse its PTANs as a result of revalidation, the MAC shall process those requests, if appropriate (based on payment localities, etc.).

## 15.29.4.1 – Revalidation Application Received and Development Required

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

If the revalidation application is received but requires development (i.e., missing application fee, hardship request, reassignments and/or employment arrangements, documentation, signature, etc.), the MAC shall notify the provider or supplier via mail, phone, fax or email. MACs shall develop for all of the missing information in one development request. Providers and suppliers shall be given 30 days to respond to the MAC's request and may submit the missing information via mail, fax, or e-mail containing scanned documentation (this includes missing signatures and dates). The provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post revalidation application approval.

If licensure and/or educational requirements (i.e., non-physician practitioner's degree or diploma) can be verified online, the MAC shall not require the provider/supplier to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again with their revalidation application. The MAC may utilize the existing documentation for verification. Residency information shall also not be required as part of revalidation. The MAC shall not require further development for data that is missing on the provider/supplier's revalidation application if the information is disclosed (1) elsewhere on the application, or (2) in the supporting documentation submitted with the application with the exception of the following items:

- Adverse legal action data
- Legal business name (LBN)
- Tax identification number (TIN)
- NPI-legacy number combinations
- Supplier/Practitioner type
- "Doing business as" name
- Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

MACs shall not require providers/suppliers to include the PTAN(s) in section 2 or 4 on the revalidation application, provided they have included the necessary information (NPI, TIN, LBN, DBA, etc.) for the MACs to appropriately make the association. If the PTAN is not submitted but is needed to make the connection, MACs shall use the shared systems, PECOS or their provider files as a resource before developing back to the provider/supplier.

MACs shall not develop for the EFT form if the provider/supplier has either the 05/2010 or 09/13 version of CMS 588 (EFT) on file. If an EFT form is submitted along with a bank letter or voided check, MACs may verify that the LBN matches and develop to process the application accordingly.

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

In scenarios where a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments and/or employment arrangements, the MAC shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassignments and/or employment arrangements not accounted for. If no response is received within 30 days, the MAC shall revalidate the single reassignment and deactivate the reassignments and/or employment arrangements within the enrollment records that were not revalidated.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc).

To illustrate, in scenario #1 the MAC issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the MAC but only addresses the reassignment for Group A. The MAC develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application is still considered in progress, the provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignment information, even post revalidation application approval. The revalidation application is processed to completion and the provider experiences no break in billing.

In scenario #2 the MAC issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the MAC but only addresses the reassignment for Group A. The MAC develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days and the revalidation due date has passed. Group A's reassignment is revalidated. Group B & C's reassignments and/or employment arrangements are deactivated effective with the date deactivation action is taken due to non-response or incomplete response to a development request. The approval letter issued by the MAC will identify the reassignments and/or employment arrangements that were revalidated and those terminated with the effective date of the reassignment or termination. The provider is required to submit a full application (CMS-855R) to reactivate the reassignment. The effective date for the reactivation is based on the receipt date of the CMS-855R. In this scenario the provider does experience a break in billing.

In this scenario, the entire enrollment shall not be deactivated; only the non-response reassignments and/or employment arrangements shall be deactivated and the other reassignments and/or employment arrangements revalidated.)

If other missing information is not received within 30 days, MACs shall deactivate the provider/supplier within 25 days after the development due date and notify the provider/supplier of the deactivation using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5. After deactivation, the provider shall be required to submit an entirely new application in order to reactivate their PTANs. Supporting documentation received may be used, if needed, for subsequent application submissions.

## 15.29.4.3 – Revalidation Received After a Deactivation Occurs

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

MACs shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The MAC shall process the application as a reactivation. The provider/supplier shall maintain their original PTAN but the MAC shall reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN using Action Reason (A/R) codes in the Multi-Carrier Claims System (MCS) based on the receipt date of the application *along with applying the retrospective billing date if appropriate*. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated for non-response to revalidation). This requirement also applies to group members whose reassignment association was terminated when the group was deactivated.

Since the issuance of PTANs and effective dates for Part A certified providers/suppliers, including ASC's and Portable X-Ray, are determined by the RO and the deactivation action does not terminate their provider agreement, MACs shall allow the provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed.

When processing the revalidation application after a deactivation occurs, the contractor shall not:

• Require any provider/supplier whose PTAN(s) have been deactivated to obtain a new State survey or accreditation as a condition of revalidation

## 15.29.4.5 – Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed

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

If the revalidation due date has been posted (*seven* months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that *seven* month timeframe, MACs shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and MACs shall not develop for the missing information, since they were established after the revalidation notice was issued. MACs shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.

To illustrate, Dr. Doe submits a CMS-855R application to his MAC to add a new reassignment to Browns Medical Center. Soon after he checks https://data.cms.gov/revalidation and notices that he is due for revalidation in the next *7* months. He submits his revalidation application to his MAC but does not include the reassignment for Browns Medical Center since it is in progress and an approval notification has not been issued. The MAC finalizes the reassignment changes and then proceeds with processing the revalidation application. The MAC shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

If a revalidation and change of information application is received concurrently, the MACs shall merge the two applications and process accordingly.

## 15.29.7 – Large Group Revalidation Coordination

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

In addition to providing the finalized revalidation list with MAC confirmed due dates, CMS will provide a list of large groups affected by this notification, including the individual providers reassigning benefits to their group that appear on the *seven* month list. MACs may stagger the large group mailings however they see fit to ensure the group receives notification that providers within their group will be receiving a request to revalidate in the next *seven* months. MACs shall send the notification letter to the Authorized/Delegated

Official or the enrollment contact person. MACs may send the group notices via email utilizing the email addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS).

MACs shall indicate **"IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request"** in the subject line to differentiate this from other emails. MACs shall use the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 to notify the large groups by attaching the letter in the body of the email. The letter should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the group notice if sent via email. If all of the emails the notice is sent to are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 90 to 105 day timeframe. MACs do not need to mail a notification if one or a few of the emails are returned as undeliverable, but one or more have been delivered successfully. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record, then MACs shall mail the notice to the group's correspondence address.

MACs shall include with the notification letter a spreadsheet identifying the individual providers that will be revalidated. The spreadsheet shall contain the Provider's Name, National Provider Identifier (NPI) and Specialty. This information will be provided as part of the list supplied by CMS.

The large group list will contain only those large groups consisting of 200 or more reassignments. Groups with less than 200 reassignments will not appear on the list and are not required to be emailed or mailed a group notification letter; however, all reassignment information will be available at https://data.cms.gov/revalidation for providers and suppliers to view.

MACs shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter. The enrollment analysts shall work directly with the group's enrollment contact person or the Authorized/Delegated Official on file.

MACs shall allow large groups to submit a spreadsheet identifying those providers that are no longer practicing at their group in lieu of submitting CMS-855R termination applications. The spreadsheet shall be accompanied by a letter signed by the Authorized/Delegated Official of the group. This process is only acceptable for large groups who are completing their revalidation and coordinating directly with the MAC.