

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 435	Date: October 19, 2012
	Change Request 8019

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part IX

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to continue the process of updating chapter 15 of the PIM.

EFFECTIVE DATE: November 20, 2012

IMPLEMENTATION DATE: November 20, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/15.5.2.2/Correspondence Address and E-mail Addresses
R	15/15.5.4.1/Section 4 of the Form CMS-855A
R	15/15.5.4.2/Section 4 of the Form CMS-855B
R	15/15.5.4.3/Section 4 of the Form CMS-855I
R	15/15.7.7.1.4/Intervening Change of Ownership (CHOW)
R	15/15.7.7.3/Reserved for Future Use
R	15/15.7.8.5/Reserved for Future Use
R	15/15.8.4/Denials
R	15/15.16/Ordering/Certifying Suppliers Who Do Not Have Medicare Billing Privileges
R	15/15.16.1/Ordering/Certifying Suppliers - Background
R	15/15.16.2/Processing Initial Form CMS-855O Submissions
R	15/15.16.4/Form CMS-855O Revocations
R	15/15.27.1/CMS or Contractor Issued Deactivations
R	15/15.27.2/Revocations
R	15/15.27.3/Special Instructions Regarding Revocation Reason 8
R	15/29.1/Reserved for Future Use

III. FUNDING:

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

No additional funding will be provided by CMS; contractor/s activities are to be carried out with their operating budgets.

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

**Business Requirements
Manual Instructions**

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

Attachment – Business Requirements

Pub. 100-08	Transmittal:435	Date: October 19, 2012	Change Request: 8019
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SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part IX

Effective Date: November 20, 2012

Implementation Date: November 20, 2012

I. GENERAL INFORMATION

A. Background: This change request (CR) is the ninth in a series of transmittals designed to update chapter 15 of the PIM. While the majority of the revisions in this CR are editorial in nature, there are several policy additions and changes related to (1) correspondence addresses, (2) out-of-state practice locations, (3) submission of change of ownership (CHOW) applications after an initial or CHOW application has been submitted, (4) the referral of potential denial and revocation actions to the Provider Enrollment Operations Group (PEOG), and (5) the scope of revocations and re-enrollment bars.

B. Policy: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A R I E R	R H H I S	Shared-System Maintainers				OTHER
						F I S S	M I C S	V M S	C W F		
8019.1	The contractor shall observe the policy revisions in this CR regarding correspondence addresses, e-mail addresses, and out-of-state practice locations.	X		X	X	X					
8019.2	In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the CMS Regional Office (RO), the contractor shall abide by the instruction in business requirements 8019.2.1 through 8019.2.5.	X		X		X					
8019.2.1	If the provider submits an initial application followed by a CHOW application and a recommendation for approval has not yet been made with respect to the initial application, the contractor shall reject both	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	applications and require the provider to re-submit an initial application with the new owner's information.										
8019.2.2	If the provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the State/RO in the same package. The accompanying notice/letter to the State/RO shall explain the situation.	X		X		X					
8019.2.3	If the provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made, the contractor shall (1) reject the CHOW application, (2) notify the State/RO via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information, and (3) request via letter that the provider submit a new initial CMS-855A application containing the new owner's information within 30 days of the date of the letter.	X		X		X					
8019.2.3.1	If the provider fails to submit the CMS-855A application referred to in (3) in business requirement 8019.2.3, the contractor shall reject the initial application and notify the provider and the State/RO of this via letter. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	the provider and the State/RO accordingly.										
8019.2.3.2	If the provider submits the CMS-855A application referred to in (3) in business requirement 8019.2.3, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the State/RO with an explanation of the situation.	X		X		X					
8019.2.3.3	If the newly submitted application referred to in business requirement 8019.2.3 is denied, however, the initially submitted application is denied as well and the contractor shall notify the provider and the State/RO accordingly.	X		X		X					
8019.2.4	If the provider submits a CHOW application followed by another CHOW application and a recommendation for approval has been made for the first application, the contractor shall (1) notify the State/RO via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information, and (2) process the new CHOW application as normal.	X		X		X					
8019.2.4.1	If a recommendation for approval is made for the new CHOW application, the contractor shall send the revised CHOW package to the State/RO with an explanation of the situation; the first CHOW application becomes moot.	X		X		X					
8019.2.4.2	If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the State/RO accordingly.	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
8019.3	Prior to sending a denial letter to the provider or supplier, the contractor shall obtain approval of both the denial and the denial letter from its PEOG Business Function Lead (BFL) if the denial involves: (1) situations (d), (e), (g) or (h) under Denial Reason 1 in section 15.8.4 of chapter 15; or (2) §424.530(a)(2), (a)(3), or (a)(4).	X		X	X	X					
8019.4	If a revoked provider or supplier submits a corrective action plan (CAP) for a revocation that was based on §424.535(a)(2), (a)(3), or (a)(5), the contractor shall notify the provider or supplier that the CAP cannot be accepted.	X			X						
8019.5	In cases where the provider or supplier fails to respond to a revalidation or other request for information, the contractor shall only use deactivate reason § 424.540(a)(3) if CMS has explicitly instructed the contractor to do so in lieu of revocation reason § 424.535(a)(1).	X		X	X	X					
8019.6	Prior to sending a revocation letter, the contractor shall obtain approval of both the revocation and the revocation letter from its PEOG BFL in the situations described in section 15.27.2(B) of chapter 15.	X		X	X	X					
8019.7	The contractor shall not apply a re-enrollment bar if the revocation (1) is based on §424.535(a)(1), <u>and</u> (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information.	X		X	X	X					
8019.8	For situations (a), (b), (f), and (g) in Revocation Reason 1 (see section 15.27.2 of chapter 15) and for revocations under § 424.535(a)(5), (a)(6) and (a)(11), the contractor shall apply the revocation and the	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
		M A C	M A C				F I S S	M C S	V M S	C W F	
	re-enrollment bar in accordance with the chart in section 15.27.2 of chapter 15.										
8019.9	If the contractor suspects that (1) a revoked provider is attempting to re-enroll under another name or business identity in order to circumvent a re-enrollment bar or (2) a provider is attempting to re-enroll a revoked practice location for the same reason, it shall contact its PEOG BFL for guidance.	X		X	X	X					
8019.10	If the contractor learns via any means (e.g., submission of a Form CMS-855, referral from Zone Program Integrity Contractor or law enforcement, notice from another contractor) that an enrolled provider or supplier has had a final adverse action imposed against it, the contractor shall refer the matter to its PEOG BFL for guidance.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
		M A C	M A C				F I S S	M C S	V M S	C W F	
8019.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In	X		X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I I S S	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact: Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov.

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

VI. FUNDING

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

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

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS 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.

Medicare Program Integrity Manual

Chapter 15 - Medicare Enrollment

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(Rev.435)

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- 15.16.1 – Ordering/*Certifying* Suppliers – Background
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15.5.2.2 – Correspondence Address *and E-mail Addresses* *(Rev.435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)*

A. Correspondence Address - Background

The correspondence address must be one where the contractor *can contact* the applicant to resolve any issues once the provider is enrolled in the Medicare program. It *can be any address the provider chooses, including that of a* billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). *The provider, however, remains ultimately responsible for all Medicare enrollment-related correspondence that the contractor sends to him/her/it at this address. For instance, if a provider uses its chain home office as the correspondence address, the provider is still the party responsible for replying to revalidation letters, requests for information, etc.*

The contractor shall call the telephone number listed in this section to verify that the contractor can *get in touch with* the applicant. If an answering service appears and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant or an official thereof. The contractor only needs to verify that the applicant can be reached at this number.

B. Contact Person

The contractor should use the contact person listed in section 13 of the Form CMS-855 for all communications directly related to the provider's submission of an initial enrollment application, change of information request, etc. All other provider enrollment-oriented matters shall be directed to the correspondence address. For instance, assume a provider submits an initial Form CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the Form CMS-855 submission between March 1 and April 15 should be sent to the contact person (or, if section 13 is blank, to an authorized/delegated official or the individual practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Assume further that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications directly related to the change request should go to the designated contact person between August 1 and August 30.

Notwithstanding the above, all approval (or recommendation for approval) and denial letters should be sent to the contact person. However, the contractor retains the discretion to send the letter to another address listed on the Form CMS-855 if circumstances dictate.

The contractor has the discretion to determine whether a particular communication is "specifically related" to a Form CMS-855 submission or whether a particular communication is "provider enrollment-oriented."

C. E-mail Addresses

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

15.5.4.1 – Section 4 of the Form CMS-855A

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

A. General Information

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

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

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

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

B. Verification of HHA Sites

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

C. Out-of-State Practice Locations

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

- The location is not part of a separate organization (e.g., a separate corporation, partnership),*
- The location does not have a separate tax identification number (TIN) and legal business name (LBN),*
- The State in which the new location is being added does not require the location to be surveyed,*
- The applicable RO does not require the new location or its owner to sign a separate provider agreement, and*
- The location is not a federally qualified health center (FQHCs are required to separately enroll each site)*

Consider the following examples:

- 1. The contractor's jurisdiction consists of States X, Y and Z. Jones Skilled Nursing Facility (JSNF), Inc., is enrolled in State X with 3 sites. It wants to add a fourth site in State Y. The new site will be under JSNF, Inc. JSNF will not be establishing a separate corporation, LBN or TIN for the site, and - per the State and RO - a separate survey and provider agreement are not necessary. Since all 5 conditions above are met, JSNF can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.*
- 2. The contractor's jurisdiction consists of States X, Y and Z. JSNF, Inc., is enrolled in State X with 3 locations. It wants to add a fourth location in State Y, but under a newly created, separate legal entity - JSNF, LP. The fourth location must be enrolled via a separate, initial Form CMS-855A.*
- 3. The contractor's jurisdiction consists of States X, Y and Z. Jones Hospice (JH), Inc., is enrolled in State X with 1 location. It wants to add a second location in State Z under JH, Inc. However, it has been determined that a separate survey and certification of the new location are required. A separate, initial Form CMS-855A for the new location is required.*

15.5.4.2 – Section 4 of the Form CMS-855B

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

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

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

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

B. Reassignment of Benefits

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

C. Ambulance Companies

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

- Each site at which its vehicles are garaged in section 4A.
- Each site from which its personnel are dispatched in section 4A.
- Its base of operations – which, for ambulance companies, is their primary headquarters – in section 4E.

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

D. Out-of-State Practice Locations

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

- *The location is not part of a separate organization (e.g., a separate corporation, partnership),*
- *The location does not have a separate tax identification number (TIN) and legal*

business name (LBN),

- The State in which the new location is being added does not require the location to be surveyed,*
- The applicable RO does not require the new location or its owner to sign a separate supplier agreement, and*
- The location is not an independent diagnostic testing facility (IDTFs are required to separately enroll each site)*

Consider the following examples:

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

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

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

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

15.5.4.3 – Section 4 of the Form CMS-855I

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

A. Solely-Owned Organizations

The former practice of having solely-owned practitioner organizations (as explained and defined in section 4A of the CMS-855I) complete a CMS-855B, a CMS-855R, and

a CMS-855I has been discontinued. All pertinent data for these organizations can be furnished via the CMS-855I alone. The contractor, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. **NOTE:** A solely-owned supplier type that normally completes the CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though section 4A makes mention of solely-owned LLCs. Use of section 4A of CMS-855I is limited to suppliers that perform physician or practitioner services.

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

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

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

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

B. Individual Affiliations

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

C. Practice Location Information

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

D. Sole Proprietor Use of EIN

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

E. NPI Information for Groups

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

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

F. Out-of-State Practice Locations

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

- The location is not part of a separate organization (e.g., a separate solely-owned corporation), and*
- The location does not have a separate tax identification number (TIN) and legal business name (LBN)*

Consider the following examples:

- 1. The contractor's jurisdiction consists of States X, Y and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. He wants to add a third location in State Y under his social security number and his sole proprietorship's employer identification number. He can add the third location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure). To the extent required, the contractor shall create a separate PECOS enrollment record for the State Y location.*
- 2. The contractor's jurisdiction consists of States X, Y and Z. Dr. Jones, LLC (a solely-owned limited liability company) is enrolled in State X with 2 locations. Dr. Jones wants to add a third location in State Y but as a sole proprietorship, not as part of Dr. Jones, LLC. Since the new location is not part of the same organizational entity, it must be enrolled via a separate, initial Form CMS-855I.*

15.7.7.1.4 - Intervening *Change of Ownership (CHOW)*

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

(This section does not apply to home health agencies)

In situations where (1) the provider submits a *Form* CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is subsequently submitted but before the contractor has received *the tie-in notice from the CMS Regional Office (RO)*, the contractor shall abide by the following:

- *Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application* – The contractor shall reject both applications and require the provider to re-submit an initial application with the new owner's information.
- *Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application* - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the State/RO in the same package. The accompanying notice/letter to the State/RO shall explain the situation.
- *Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made* – The contractor shall:
 - *Reject the CHOW application.*
 - *Notify the State/RO via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.*
 - *Request via letter that the provider submit a new initial CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall reject the initial application and notify the provider and the State/RO of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the State/RO with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the State/RO accordingly.*

- *Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:*
 - *Notify the State/RO via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.*
 - *Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the State/RO with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the State/RO accordingly.*

15.7.7.3 – Reserved for Future Use

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

15.7.8.5 – Reserved for Future Use

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

15.8.4 – Denials

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

A. Denial Reasons

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

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

If the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the State/Regional Office (RO). The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider. The contractor shall copy the State and the RO on said letter.

Denial Reason 1 (42 CFR §424.530(a)(1))

The provider or supplier is determined not to be in compliance with the Medicare enrollment requirements described in this section or on the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR part 488. Such non-compliance includes, but is not

limited to, the following situations:

- a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- c. The provider or supplier is not appropriately licensed.
- d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.
- e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as.
- f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official. *(This includes situations where, for instance, an owner, partner, managing employee, etc., does not have an SSN/EIN because the individual or entity is foreign.)*
- g. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).
- h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - the contractor’s denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter. **NOTE:** The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

Denial Reason 2 (42 CFR §424.530(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- Excluded from Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or

- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

Denial Reason 3 (42 CFR §424.530(a)(3))

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

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

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

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

- Any felonies outlined in section 1128 of the Social Security Act.

While, as discussed in section 15.27.2(D) of this chapter, the contractor shall establish an enrollment bar for providers and suppliers whose billing privileges are revoked, this does not preclude the contractor from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact its *PEOG BFL* for assistance.

Denial Reason 4 (42 CFR §424.530(a)(4))

The provider or supplier submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program.

Denial Reason 5 (42 CFR §424.530(a)(5))

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

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

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

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

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

Denial Reason 7 (42 CFR §424.530(a)(7))

The current owner (as defined in §424.502), physician or non-physician practitioner has been placed under a Medicare payment suspension as defined in §405.370 through §405.372.

Denial Reason 8 (42 CFR §424.530(a)(8))

A home health agency (HHA) submitting an initial application for enrollment:

- Cannot, within 30 days of a CMS or Medicare contractor request, furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement in 42 CFR §489.28(a); or
- Fails to satisfy the initial reserve operating funds requirement in 42 CFR §489.28(a).

Denial Reason 9 (42 CFR §424.530(a)(9))

The institutional provider's (as that term is defined in 42 CFR §424.502) hardship exception request is not granted, and the institutional provider does not submit the required application fee within 30 days of notification that the hardship exception request was not approved.

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use 42 CFR §424.530(a)(1) as a basis for denial when the institutional provider:

- Does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes, or
- Submits the fee, but it cannot be deposited into a government-owned account.)

Denial Reason 10 (42 CFR §424.530(a)(10))

The provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium. (This denial reason applies to initial enrollment applications and practice location additions.)

B. Denial Letters

1. General

When a decision to deny is made, the contractor shall send a letter to the provider identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of those shown in section 15.24 et seq. of this chapter.

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

2. Prior PEOG Approval

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

- *Situation (d), (e), (g) or (h) under Denial Reason 1 above.*
- *§424.535(a)(2), (a)(3), or (a)(4).*

C. Post-Denial Submission of Enrollment Application

A provider or supplier that is denied enrollment in the Medicare program may not submit a new enrollment application until either of the following has occurred:

- If the denial was not appealed, the provider or supplier's appeal rights have lapsed, or
- If the denial was appealed, the provider or supplier has received notification that the determination was upheld.

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the

provider.

As stated in 42 CFR §424.530(c), if the denial was due to adverse activity (e.g., exclusion, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

E. Provider Enrollment Appeals Process

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

F. Final Adverse Actions

See section 15.5.3 of this chapter for information regarding the circumstances in which the contractor shall refer final adverse actions to its PEOG BFL.

15.16 – Ordering/Certifying Suppliers Who Do Not Have Medicare Billing Privileges

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

15.16.1 – Ordering/*Certifying* Suppliers – Background

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

A. Who Can Order/Certify

Generally, depending upon State law, the following physicians and non-physician practitioners are permitted to order or *certify* items or services for Medicare beneficiaries:

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry
- Doctors of optometry
- Physician assistants
- Certified clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Certified nurse midwives
- Clinical social workers

Most physicians and non-physician practitioners enroll in Medicare so they can receive reimbursement for covered services to Medicare beneficiaries. However, some

physicians and non-physician practitioners who are not enrolled in Medicare via the Form CMS-855I may wish to order or *certify* items or services for Medicare beneficiaries. These individuals can become eligible to do so by completing the Form CMS-855O via paper or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) process.

NOTE: It is important to *observe* that physicians and non-physician practitioners that complete the Form CMS-855O do not and will not send claims to a Medicare contractor for services they furnish. They are not afforded Medicare billing privileges for the purpose of submitting claims to Medicare directly for services that they furnish to beneficiaries. Such persons may be:

- Employed by the Department of Veterans Affairs (DVA)
- Employed by the Public Health Service (PHS)
- Employed by the Department of Defense (DOD) Tricare
- Employed by the Indian Health Service (IHS) or a tribal organization
- Employed by a federally qualified health center (FQHC), rural health clinic (RHC), or critical access hospital (CAH)
- Licensed residents and physicians in a fellowship (*see subsection B*)
- Dentists, including oral surgeons
- Pediatricians

B. CMS Final Rule 6010-F

CMS-6010-F was published in the Federal Register on April 27, 2012. It set forth and/or reiterated several policies including, but not limited to, the following:

- 1. Residents (as defined in 42 CFR § 413.75 and which includes interns and fellows) who are enrolled in an accredited graduate medical education program in a State that licenses or otherwise enables such individual to practice or order these items or services may enroll in Medicare to order and certify.*
- 2. To order and certify for Medicare items and services, a provider or supplier must be enrolled in either PECOS or the Medicare contractor's legacy system.*
- 3. The ordering/certifying provisions of the final rule only apply to items of durable medical equipment, prosthetics, orthotics and supplies, imaging and clinical laboratory services, and home health services.*

An interim final rule – CMS-6010-IFC, which was published in the Federal Register on May 5, 2010 – used the terms “refer” and “referring,” rather than “certify” and “certifying.” The April 27, 2012 final rule stated that the latter two terms should be used instead of “refer” and “referring.”

15.16.2 – Processing Initial Form CMS-855O Submissions *(Rev.435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)*

A. Prescreening

Upon receipt of an initial Form CMS-855O (or - for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) submissions - a certification statement), the contractor shall:

- Pre-screen the form in accordance with the same procedures that are required for pre-screening Form CMS-855I applications.
- Create a logging & tracking (L & T) record.

NOTE: The physician/non-physician practitioner need not submit a Form CMS-460, a Form CMS-588, or an application fee with its Form CMS-855O.

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855O. If the contractor determines that one or more of these reasons applies, it shall return the form in accordance with the instructions outlined in that section.

B. Verification

Unless stated otherwise in another CMS directive, the contractor shall verify all of the information on the Form CMS-855O. This includes, but is not limited to:

- Verification of the individual's name, date of birth, social security number, and National Provider Identifier (NPI).
- Verification that the individual meets the requirements for his/her supplier type. (The contractor reserves the right to request that the individual submit documentation verifying his or her professional licensure, credentials, or education.)
- Verification that the individual is of a supplier type that can legally order or *certify*.
- Reviewing the Medicare Exclusion Database (MED) and General Services Administration (GSA) Excluded Parties List System to ensure that the individual is not excluded or debarred.

If, at any time during the pre-screening or verification process, the contractor needs additional or clarifying information from the physician/non-physician practitioner, it shall follow existing CMS instructions for obtaining said data (e.g., sending a developmental letter). The information must be furnished to the contractor within 30

calendar days of the contractor's request.

C. Timeliness

The contractor:

- Shall process 80 percent of all paper initial Form CMS-855O applications within 60 calendar days of receipt, and 95 percent of such applications within 90 calendar days of receipt.
- Shall process 90 percent of all Web-based initial Form CMS-855O applications within 45 calendar days of receipt, process 95 percent of such applications within 60 calendar days of receipt, and process 99 percent of such applications within 90 calendar days of receipt.
- Shall process 98 percent of all initial Form CMS-855O applications in full accordance with the instructions in this section 15.16.2 (with the exception of the timeliness standards mentioned above) and all other applicable CMS directives.

For purposes of these standards, the timeliness processing clock begins on the date that the paper application or Web-based certification statement was received in the contractor's mailroom.

D. Disposition

Upon completion of its review of the form, the contractor shall approve, deny, or reject it.

Grounds for denial are as follows:

- The supplier is not of a type that is eligible to use the Form CMS-855O.
- The supplier is not of a type that is eligible to order or *certify* items or services for Medicare beneficiaries.
- The supplier does not meet the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the MED and/or debarred per the GSA Excluded Parties List System.

If the contractor believes that another ground for denial exists for a particular submission, it should contact its Provider Enrollment Operations Group *Business Function Lead* for guidance.

The Form CMS-855O shall be rejected if the supplier fails to furnish all required

information on the form within 30 calendar days of the contractor's request to do so. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a).

When denying or rejecting the Form CMS-855O submission, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter to the supplier notifying him or her of the denial or rejection and the reason(s) for it. The letter shall follow the formats outlined in sections 15.24.22 (rejections) and 15.24.23 (denials) of this chapter. Denial letters shall be sent via certified mail. Rejection letters shall be sent by mail or e-mail. **NOTE:** A denial triggers appeal rights. A rejection does not.

If the Form CMS-855O is approved, the contractor shall: (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval. The letter shall follow the format outlined in section 15.24.21 of this chapter.

E. Miscellaneous

NOTE: The contractor shall observe the following:

1. The supplier shall be treated as a non-participating supplier (or "non-par").
2. If the supplier is employed by the DVA, the DOD, or the IHS, he or she – for purposes of the Form CMS-855O - need only be licensed or certified in one State. Said State need not be the one in which the DVA or DOD office is located.
3. Nothing in sections 15.16.2 through 15.16.4 affects any existing CMS instructions regarding the processing of opt-out affidavits.
4. Suppliers cannot submit an abbreviated version of the Form CMS-855I in lieu of the Form CMS-855O.
5. The effective date of enrollment shall be the date on which the contractor received the paper form or Web-based certification statement in its mailroom.
6. If the supplier's Form CMS-855O has been approved and he or she later wants to obtain Medicare billing privileges, he or she must voluntarily withdraw his or her Form CMS-855O enrollment prior to receiving Medicare billing privileges. (The supplier, of course, must complete the Form CMS-855I in order to receive Medicare billing privileges.)

15.16.4 – Form CMS-855O Revocations

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

If the contractor determines that grounds exist for revoking the supplier's Form CMS-

855O enrollment, it shall:

- Switch the supplier's Provider Enrollment, Chain and Ownership System (PECOS) record to a "revoked" status,
- End-date the PECOS record, and
- Send a letter via certified mail to the supplier stating that his or her Form CMS-855O enrollment has been revoked. The letter shall follow the format outlined in section 15.24.24 of this chapter.

Grounds for revoking the supplier's Form CMS-855O enrollment are as follows:

- The supplier is no longer of a type that is eligible to order or *certify*.
- The supplier no longer meets the licensure, certification or educational requirements for his or her supplier type.
- The supplier is excluded per the Medicare Exclusion Database (MED) and/or debarred per the General Services Administration (GSA) Excluded Parties List System.

For purposes of the Form CMS-855O only, the term "revocation" effectively means that:

- The supplier may no longer order or *certify* Medicare services based on his or her having completed the Form CMS-855O process.
- If the supplier wishes to submit another Form CMS-855O, he or she must do so as an initial applicant.

There are appeal rights associated with the revocation of a supplier's Form CMS-855O enrollment.

15.27.1 – CMS or Contractor Issued Deactivations

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

A. General Instructions

1. Deactivation Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor may deactivate a provider or supplier's Medicare billing privileges when:

- 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;
- 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; or
- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

Pursuant to 42 CFR § 424.540(a)(3), the contractor may also deactivate a provider or supplier's Medicare billing privileges if the provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. This deactivation reason, however, should only be used in situations where CMS has explicitly instructed the contractor to use § 424.540(a)(3) in lieu of revocation reason § 424.535(a)(1) in cases where the provider or supplier fails to respond to a revalidation or other request for information. Absent such a directive from CMS, the contractor shall use § 424.535(a)(1) in such situations.

2. Effects of Deactivation

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

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation.

Providers and suppliers that fail to promptly notify the contractor of a change (as described above) must submit a complete Medicare enrollment application to reactivate their Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement. However, per 42 CFR §424.540(b)(3)(i), and as described in subsection E below, an HHA whose billing privileges are deactivated must undergo a State survey or obtain accreditation prior to having its billing privileges reactivated.

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated *PEOG* contractor liaison no later than

the last calendar day of each month.

B. Special Reactivation Instructions for Part B Suppliers

(This section 27.1(B) does not apply to: (1) providers and suppliers that complete the CMS-855A application, and (2) suppliers of durable medical equipment, prosthetics, orthotics and suppliers (DMEPOS)).

To ensure that a supplier that has reactivated its Medicare billing privileges does not become subject to a second deactivation for non-billing within 30 days of the reactivation, the contractor shall:

1. End-date the existing Provider Transaction Access Number (PTAN)-National Provider Identifier (NPI) combination in sections 1 and 4 of the Provider Enrollment, Chain and Ownership System (PECOS) with the non-billing end-date in MCS, and

2. Issue a new Provider Transaction Access Number (PTAN) to the provider or supplier, and associate the new PTAN with the NPI in sections 1 and 4 of PECOS.

For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals, the contractor shall establish the reactivation effective date as the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location.

The exception to this is if the supplier has at least one other enrolled practice location (under the same TIN) for which it is actively billing Medicare; here, the contractor shall establish and enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later. To illustrate, if the supplier has only one enrolled practice location and that site is deactivated for non-billing, the effective date is the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location. On the other hand, suppose the supplier has two enrolled locations – X and Y - under its TIN. Location X is actively billing Medicare, but Y is deactivated for non-billing. The reactivation effective date for Y would be the later of: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS. This is because the supplier has at least one other location – Location X – that is actively billing Medicare.

For individual and organizational suppliers other than those identified in the beginning of the previous paragraph, the contractor shall enter the effective date as either: (a) the

date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later.

If the supplier's PTAN is only established in MCS, no action is required if the end-dated non-billing number is not in PECOS.

C. DMEPOS Deactivation

The National Supplier Clearinghouse (NSC) shall require a DMEPOS supplier whose billing privileges are deactivated for non-submission of claims (see CFR 42 CFR §424.540) to submit a new Medicare enrollment application and meet all applicable enrollment criteria, including a site visit, and accreditation when applicable, before an applicant can be approved. The NSC may not establish a retrospective billing date for a DMEPOS supplier whose billing privileges were deactivated due to claims inactivity.

D. Deactivation and Appeals Rights

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

15.27.2 – Revocations

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

A. Revocation Reasons

Except in the situations outlined in section 15.27.2(B) below, the contractor may issue a revocation without prior approval from the Provider Enrollment Operations Group (PEOG).

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

Revocation Reason 1 (42 CFR §424.535(a)(1))

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 CFR Part 488.

Noncompliance includes, but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider or supplier has failed to pay any user fees as assessed under 42 CFR Part 488.

Other situations in which the contractor shall use §424.535(a)(1) as a revocation reason include, but are not limited to, the following:

- a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- c. The provider or supplier is not appropriately licensed.
- d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.
- e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.
- f. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official. *(This includes situations where, for instance, an owner, partner, managing employee, etc., does not have an SSN/EIN because the individual or entity is foreign.)*
- g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. *(NOTE: This revocation reason should not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason § 424.540(a)(3) in lieu thereof.)*
- h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - the contractor's revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 *et seq.* of this chapter. **NOTE:** The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance with.

Revocation Reason 2 (42 CFR §424.535(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated

official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

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

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

If an excluded party is found, the contractor shall notify its *PEOG Business Function Lead (BFL)* immediately. PEOG will notify the Government Task Leader (GTL) for the appropriate Zone Program Integrity Contractor. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

Revocation Reason 3 (42 CFR §424.535(a)(3))

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

(i) Offenses include—

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

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

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

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

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

An enrollment bar issued pursuant to 42 CFR §424.535(c) does not preclude CMS or its

contractors from denying re-enrollment to a provider or supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all criteria necessary to enroll in *Medicare*.

Revocation Reason 4 (42 CFR §424.535(a)(4))

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

Revocation Reason 5 (42 CFR §424.535(a)(5))

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

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

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

Revocation Reason 6 (§424.535(a)(6))

(i) (A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or

(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(ii) (A) Either of the following occurs:

(1) CMS is not able to deposit the full application amount into a government-owned account; or

(2) The funds are not able to be credited to the United States Treasury;

(B) The provider or supplier lacks sufficient funds in the account at the banking

institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

Revocation Reason 7 (42 CFR §424.535(a)(7))

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

Revocation Reason 8 (42 CFR §424.535(a)(8))

The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service.

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

Revocation Reason 9 (42 CFR §424.535(a)(9))

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

NOTE: The following with respect to Revocation 9:

- This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

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

Revocation Reason 10 (42 CFR §424.535(a)(10))

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

Revocation Reason 11 (42 CFR §424.535(a)(11))

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

Revocation Reason 12 (42 CFR §424.535(a)(12))

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

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

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

B. Prior PEOG Approval

Prior to sending a revocation letter, the contractor shall obtain approval of both the revocation and the revocation letter from its PEOG BFL in the following situations:

- *Any revocation, regardless of the reason, involving (1) a provider or supplier that completes a Form-855A application, (2) an ambulatory surgical center, or (3) a portable x-ray supplier.*
- *A revocation involving a non-certified provider or non-certified supplier that is based on:*
 - *Situation (d), (e) or (h) under Revocation Reason 1 above, or*
 - *§ 424.535(a)(2), (a)(3), (a)(4), (a)(7), (a)(8), (a)(9), (a)(10) and (a)(12).*

During this review, CMS will also determine (1) the extent to which the revoked provider or supplier's other locations are affected by the revocation, and (2) the geographic application of the reenrollment bar. (See subsection F below.)

C. Effective Date of Revocations

Per 42 CFR §405.874(b)(2), a revocation is effective 30 days after CMS or its

contractor (including the National Supplier Clearinghouse (NSC)) mails the notice of its determination to the provider or supplier. However, per 42 CFR §424.535(g), a revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction as described in 42 CFR §424.535(a)(3), (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.

NOTE: In accordance with 42 CFR §424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009. Moreover, no later than 10 calendar days after the contractor assesses the overpayment, the contractor shall notify its PEOG liaison of the amount assessed.

As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

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

D. Payment

Per 42 CFR §405.874(b)(3), Medicare does not pay and a CMS contractor rejects claims for items or services submitted with a service date on or after the effective date of a provider’s or supplier’s revocation.

E. Re-enrollment Bar

As stated in 42 CFR §424.535(c), after a provider, supplier, delegated official, or authorized official has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. *Per §424.535(c), however, the reenrollment bar does not apply if the revocation (1) is based on §424.535(a)(1), and (2) stems from a provider or supplier’s failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar shall be applied.*

Unless stated otherwise in this section, the re-enrollment bar is a minimum of 1 year but not greater than 3 years, depending on the severity of the basis for revocation. The contractor shall establish the re-enrollment bar in accordance with the following:

1 year (AR 73) – License revocation/suspension that a deactivated provider (i.e., is enrolled, but is not actively billing) failed to timely report to **CMS**.

2 years (AR 74) – The provider is no longer operational.

3 years (AR 81) – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information.

For all other revocation reasons, the contractor shall contact its PEOG liaison. PEOG will establish the appropriate enrollment bar for that particular case.

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

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

F. Scope of Revocation and Reenrollment Bar

The chart below outlines the extent to which (1) a particular revocation generally applies to the provider’s other locations and (2) the re-enrollment bar applies.

<i>Revocation Reason</i>	<i>Scope of Revocation</i>	<i>Scope of Bar</i>
<i>§ 424.535(a)(1)</i>	<i>For situations (a) and (b) in Revocation Reason 1, applies only to the practice location in question, unless CMS determines otherwise. For situations (c), (d), (e) and (h) in Revocation Reason 1 above, CMS will determine. For situations (f) and (g) in Revocation Reason 1, applies to all practice locations under the provider’s PECOS or legacy enrollment record, unless CMS determines otherwise.</i>	<i>For situations (a) and (b) in Revocation Reason 1, applies only to the practice location in question, unless CMS determines otherwise. For situations (c), (d), (e) and (h) in Revocation Reason 1 above, CMS will determine. For situations (f) and (g) in Revocation Reason 1, applies to all practice locations under the provider’s PECOS or legacy enrollment record, unless CMS determines otherwise.</i>

§ 424.535(a)(2)	<i>CMS (in consultation, as needed, with the appropriate law enforcement agencies) will determine</i>	<i>CMS (in consultation, as needed, with appropriate law enforcement agencies) will determine</i>
§ 424.535(a)(3)	<i>CMS will determine</i>	<i>CMS will determine</i>
§ 424.535(a)(4)	<i>CMS will determine</i>	<i>CMS will determine</i>
§ 424.535(a)(5)	<i>Applies only to the location in question, unless CMS determines otherwise. NOTE: The specific location should be end-dated if the PECOS record contains other locations that are not being revoked. For instance, if a group practice has three locations – X, Y and Z - and Location X is determined to be non-operational, X should be end-dated; the entire PECOS record should not be placed in a “Revoked” status if Locations Y and Z are not being revoked.</i>	<i>Applies only to the location in question, unless CMS determines otherwise</i>
§ 424.535(a)(6)	<i>Applies to all practice locations under the provider’s PECOS or legacy enrollment record, unless CMS determines otherwise</i>	<i>Applies to all practice locations under the provider’s PECOS or legacy enrollment record, unless CMS determines otherwise</i>
§ 424.535(a)(7)	<i>CMS will determine</i>	<i>CMS will determine</i>
§ 424.535(a)(8)	<i>CMS will determine</i>	<i>CMS will determine</i>
§ 424.535(a)(9)	<i>CMS will determine</i>	<i>CMS will determine</i>
§ 424.535(a)(10)	<i>CMS will determine</i>	<i>CMS will determine</i>
§ 424.535(a)(11)	<i>Applies to all practice locations and branches under the revoked HHA’s provider</i>	<i>Applies to all practice locations and branches under the revoked HHA’s provider agreement</i>

	<i>agreement</i>	
<i>§ 424.535(a)(12)</i>	<i>CMS will determine</i>	<i>CMS will determine</i>

Thus, for situations (a), (b), (f), and (g) in Revocation Reason 1 and for revocations under § 424.535(a)(5), (a)(6) and (a)(11), the contractor shall apply the revocation and the re-enrollment bar in accordance with this chart. For instance, suppose Physician Group X, Inc. enrolled in Medicare in 2009. It has 3 practice locations. One of the locations has been determined to be non-operational and will be revoked. The contractor shall end-date this location but shall not end-date the other two. The re-enrollment bar only applies to the revoked location, meaning that any attempt by the provider to re-enroll the revoked location shall be rejected.

If the contractor suspects that (1) a revoked provider is attempting to re-enroll under another name or business identity in order to circumvent a re-enrollment bar or (2) a provider is attempting to re-enroll a revoked practice location for the same reason, it shall contact its PEOG BFL for guidance.

G. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(g), any physician, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

H. Final Adverse Actions

If the contractor learns via any means (e.g., submission of a Form CMS-855, referral from Zone Program Integrity Contractor or law enforcement, notice from another contractor) that an enrolled provider or supplier has had a final adverse action imposed against it, the contractor shall refer the matter to its PEOG BFL for guidance.

I. Notification to Other Contractors

If the contractor revokes a provider or supplier's Medicare billing privileges, the contractor shall determine, via a search of PECOS, whether the provider/supplier is enrolled with any other Medicare contractors. If the contractor determines that the revoked provider/supplier is indeed enrolled with another contractor(s), the revoking contractor shall notify these other contractors of the revocation. The notification shall be done via e-mail and shall contain a short description of the reason for the revocation.

Upon receipt of this notification from the revoking contractor, the receiving contractor

shall determine whether the provider or supplier's billing privileges should be revoked in its jurisdiction as well. *This may require that the contractor contact its PEOG BFL for guidance per the instructions in this chapter.*

J. Provider Enrollment Appeals Process

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

K. Summary

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

- Revoking the provider's billing privileges back to the appropriate date;
- Establishment of the applicable reenrollment bar;
- Updating PECOS to show the length of the reenrollment bar;
- Assessment of an overpayment, as applicable;
- Providing PEOG with the amount of the assessed overpayment within 10 days of the overpayment assessment; and
- Affording appeal rights.

L. Reporting Revocations/Terminations to the State Medicaid Agencies and Children's Health Program (CHIP)

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

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

Contractors shall be required to update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation action taken. Contractors shall not make any other modifications to the format of this form or

its contents. The following terms are the only authorized entries to be made on the report:

Appeal Submitted:

Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)

No - (definition: no appeal of any type has been submitted)

Appeal Type:

CAP

Reconsideration

ALJ

DAB

Appeal Status:

Under Review

Revocation Upheld

Revocation Overturned

CAP accepted

CAP denied

Reconsideration Accepted

Reconsideration Denied

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

If an appeal action has been submitted *to PEOG* for certified providers or suppliers, contractors shall access the PEOG appeal's log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to its designated *PEOG BFL*.

15.27.3 – *Special Instructions Regarding Revocation Reason 8*
(Rev.435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)

Sections 15.27.3.1 and 15.27.3.2 address revocations pursuant to 42 CFR § 424.535(a)(8). As stated in this chapter, the contractor must obtain approval from the Provider Enrollment Operations Group (PEOG) before revoking a provider or supplier under this authority. However, unless the particular circumstances of the case dictate otherwise, this approval no longer needs to be in the form of a Technical Direction Letter.

15.29.1 – *Reserved for Future Use*
(Rev.435, Issued: 10-19-12, Effective: 11-20-12, Implementation: 11-20-12)