CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11307	**Date: March 25, 2022**
	Change Request 12598

SUBJECT: Fifth General Update to Provider Enrollment Instructions in Chapter 10 of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify several provider enrollment model letters, deactivation policies, procedures for processing certain federally qualified health center applications, and other provider enrollment topics in Chapter 10 of Pub. 100-08.

EFFECTIVE DATE: March 4, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 25, 2022

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	10/10.2/10.2.1.4/Federally Qualified Health Centers (FQHCs)
R	10/10.2/10.2.1.8/Hospitals and Hospital Units
R	10/10.2/10.2.4/Other Medicare Part B Services
R	10/10.2/10.2.6/Medicare Diabetes Prevention Program (MDPP) Suppliers
R	10/10.2/10.2.8/Providers/Suppliers Not Eligible to Enroll
R	10/10.4/10.4.2.3/Additional Denial Policies
R	10/10.4/10.4.3/Voluntary and Involuntary Terminations
R	10/10.4/10.4.4/Changes of Information
R	10/10.4/10.4.5.3/Receipt and Processing of Revalidation Applications
R	10/10.4/10.4.7.2/Revocation Effective Dates and Miscellaneous Policies
R	10/10.4/10.4.8/Deactivations
R	10/10.4/10.4.8.1/Deactivation Rebuttals
R	10/10.6/10.6.1.2/Changes of Information – Skilled Nursing Facilities (SNF)
R	10/10.6/10.6.1.3/Voluntary Terminations
R	10/10.6/10.6.9/Contact Persons
R	10/10.6/10.6.10/Medicare Payment
R	10/10.6/10.6.11/Participation (Par) Agreements and the Acceptance of Assignment – General Information
R	10/10.6/10.6.12/Opting-Out of Medicare
R	10/10.6/10.6.14/Application Fees
R	10/10.6/10.6.21/Miscellaneous Enrollment Topics
R	10/10.7/Model Letters
R	10/10.7/10.7.5.1/Part A/B Certified Provider and Supplier Letter Templates – Post-Transition
R	10/10.7/10.7.12/Deactivation Model Letter
R	10/10.7/10.7.13/Rebuttal Model Letters
R	10/10.7/10.7.15/Revalidation Notification Letters
D	10/10.7/10.7.19/Model Approval Letter for Federally Qualified Health Centers (FQHCs)
D	10/10.7/10.7.20/Model Approval Letter for Voluntary Terminations Involving Certified Providers and Certified Suppliers

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: 11307	Date: March 24, 2022	Change Request: 12598

SUBJECT: Fifth General Update to Provider Enrollment Instructions in Chapter 10 of Publication (Pub.) 100-08

EFFECTIVE DATE: March 4, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 25, 2022

I. GENERAL INFORMATION

A. Background: Chapter 10 of Pub. 100-08 outlines policies related to Medicare provider enrollment and instructs contractors on the processing of Form CMS-855 provider enrollment applications. This CR will clarify several provider enrollment model letters, deactivation policies, procedures for processing certain federally qualified health center applications, and other provider enrollment topics in Chapter 10 of Pub. 100-08.

B. Policy: This CR does not contain any legislative or regulatory policies.

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	
12598.1	The contractor shall process change of ownership and change of information applications from federally qualified health centers consistent with the instructions in Section 10.2.1.4 in Chapter 10 of Pub. 100-08.	X								
12598.2	The contactor shall follow the instructions in Section 10.2.1.8(B)(7) in Chapter 10 of	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Pub. 100-08 regarding the processing of Form CMS-855A applications that report multiple transplant programs.									
12598.3	The contactor shall follow the instructions in Section 10.4.8(E) in Chapter 10 of Pub. 100-08 regarding the application of 42 Code of Federal Regulations (CFR) 424.540(a)(7).	X	X	X						
12598.4	The contactor shall follow the instructions in Section 10.6.1.3(A)(2)(b) in Chapter 10 of Pub. 100-08 regarding the application of 42 CFR 424.540(a)(8).	X	X	X						
12598.5	The contactor shall follow the instructions in Section 10.7(A)(2)(n) in Chapter 10 of Pub. 100-08 regarding model letters for sellers in a change of ownership.	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12598.6	The contractor shall be advised that a revalidating provider/supplier need not submit the most current version of the Form CMS-588 with its application unless -- (1) It has no Form CMS-588 on file at all; or (2) It is changing any of its existing Form CMS-588 data.	X	X	X						
12598.7	The contractor shall be advised of the technical clarifications and policy restatements in those sections of this CR not addressed in Business Requirements 12598.1 through 12598.6.	X	X	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): Frank Whelan, 410-786-1302 or frank.whelan@hotmail.com

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: 1

PLEASE INCLUDE THIS COMPLETED PROVIDER ENROLLMENT FORM WITH THE SUBMISSION OF REBUTTAL

Provider/Supplier Name:

_____

National Provider Identifier (NPI): _____**PTAN:**

_____

Document Control Number (DCN):_____

_____

Submitter's Email Address:

_____

Submitter's Address:_____

_____

Submitter's Fax Number (If Applicable):_____

_____

Medicare Administrative Contractor: [Insert MAC Name]_____

At minimum, the rebuttal submission must:

1) Be received within *15* calendar days from the date of the deactivation notice;

2) Specify the facts or issues with which the provider or supplier disagrees, and the reasons for disagreement;

3) Include all documentation and information the provider or supplier would like to be considered in reviewing the deactivation;

4) Be submitted in the form of a letter that is signed and dated by the individual provider, supplier, the authorized or delegated official, or a legal representative. The provider's or supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a rebuttal request. If the legal representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to constitute notice. If the legal representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with CMS. This notice of appointment must be signed and dated by the individual provider or supplier, the authorized or delegated official, or a legal representative.

Please send this form, the rebuttal submission, the deactivation letter, and all supporting documentation applicable to the rebuttal of the deactivation to the address noted in your deactivation letter, which is also listed below:

[MAC Address]

You may also email this form, the rebuttal submission, the deactivation letter, and all supporting documentation applicable to the rebuttal of the deactivation to the email address listed below:

[MAC Email Address]

You may also fax this form, the rebuttal submission, the deactivation letter, and all supporting documentation applicable to the rebuttal of the deactivation to the fax number listed below:

[MAC Fax Number]

Medicare Program Integrity Manual

Chapter 10 – Medicare Enrollment

Table of Contents

(Rev. 11307; Issued: 03- 25- 2022)

10.2.1.4 - Federally Qualified Health Centers (FQHCs)

(Rev. 11307; Issued: 03- 25- 2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Statutory Background

Section 4161(a)(2) of OBRA '90 (P.L. 101-508) amended §1861(aa) of the Act and established FQHC services as a benefit under the Medicare program effective October 1, 1991. The statutory requirements that entities must meet to be considered an FQHC for Medicare purposes are at §1861(aa)(4) of the Act. Regulations establishing the FQHC benefit and outlining the Conditions for Coverage for FQHCs were published on June 12, 1992, in the Federal Register (57 FR 24961) and became effective on the date of publication. These regulations were amended on April 3, 1996 (61 FR 14640). Section 13556 of OBRA 1993 (P.L. 103-66) amended §1861(aa) of the Act by adding outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, as entities eligible to participate in Medicare as FQHCs.

B. Requirements

FQHCs furnish services such as those performed by physicians, nurse practitioners, physician assistants, clinical psychologists, certified nurse-midwives, and clinical social workers. This also includes certain preventive services like prenatal services, immunizations, blood pressure checks, hearing screenings and cholesterol screenings. (See Pub. 100-02, chapter 13 for more information). To participate in the Medicare program, applicants seeking initial enrollment as an FQHC must submit a Form CMS-855A application to the appropriate Medicare Administrative Contractor (MAC). Even though they complete the Form CMS-855A application, FQHCs are considered Part B certified suppliers and are paid Part B benefits for FQHC services.

FQHCs are not required to obtain a state survey. However, FQHCs still must meet all applicable state and local requirements and submit all applicable licenses. Typically, the Health Resources and Services Administration (HRSA) will verify such state/local compliance by asking the FQHC to attest that it meets all state/local laws.

FQHCs can be located in a rural or urban area that is designated as either a health professional shortage area or an area that has a medically underserved population.

For purposes of Medicare enrollment, an FQHC is defined as an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR § 405.2434(a), and (as outlined in Pub. 100-07, chapter 9, exhibit 179):

- Is receiving a grant under § 330 of the Public Health Service (PHS) Act;
- Is receiving funding under a contract with the recipient of a § 330 grant, and meets the requirements to receive a grant under § 330 of the PHS Act;
- Is an FQHC "Look-Alike" (i.e., HRSA), has notified it that it meets the requirements for receiving a § 330 grant, even though it is not actually receiving such a grant);
- Was treated by CMS as a comprehensive federally funded health center as of January 1, 1990; or
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

C. Initial FQHC Applications

1. Contractor Review and Required Documents

In contrast to both past practice and the process that is normally followed with other certified provider/certified supplier types, the contractor does not make a recommendation for approval to the state/SOG Location for FQHC applications. Instead, the contractor will either approve or deny the application at the contractor level pursuant to the instructions in this section.

The following documents must be included with the FQHC's completed Form CMS-855A application:

- One signed and dated copy of the attestation statement (Exhibit 177). In order to attest to being in compliance, the facility must be open and operating when the attestation is signed. Since FQHCs must sign an agreement stipulating that they will comply with § 1861(aa)(4) of the Act and specific FQHC regulations, this statement serves as the Medicare FQHC benefit (or provider/supplier) agreement when it is also signed and dated by PEOG. (See Pub. 100-07, chapter 2, section 2826B.)

- HRSA Notice of Grant Award *(NOA)* or FQHC Look-Alike Designation that includes an address for the site of the applicant which matches the practice location reported on the Form CMS-855A. A Notice of Grant Award by HRSA verifies that the applicant qualifies as a FQHC grant recipient; the FQHC Look-Alike Designation Memo from HRSA verifies look-alike status.

- Form CMS-588; Electronic Funds Transfer (EFT) Authorization Agreement.

- Clinical Laboratory Improvement Act (CLIA) Certificate (if applicable). Facilities that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings is considered a laboratory and must meet CLIA requirements. These facilities must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed. Certain types of laboratories and laboratory tests are NOT subject to meeting CLIA requirements. One example would be facilities which serve only as collection stations. A collection station receives specimens to be forwarded to a laboratory performing diagnostics test. Pub. 100-07, chapter 6, section 6002 provides additional details regarding laboratories and laboratory tests NOT subject to CLIA requirements. It is the FQHC's responsibility to review the CLIA requirements and obtain a CLIA certificate if needed. Neither the contractor nor CMS determines whether the FQHC needs to obtain and submit a CLIA certificate.

- Copy of state license (if applicable).

2. General Processing Concepts

(A) Practice Locations - An FQHC cannot have multiple sites or practice locations. Each location must be separately enrolled and will receive its own CCN.

(B) *Date on the NOA – Both the project period (Item 6 of the NOA) and the budget period (Item 7 of the NOA) must, at a minimum, be valid through the date on which the FQHC's application was complete (as determined by the contractor). The contractor shall develop for a correct NOA date(s) if the project period and/or budget period do not meet the aforementioned requirement.*

(C) Name on Exhibit 177 - The contractor shall ensure that Exhibit 177 contains the same legal business name and address as that which the FQHC provided in Section 2

and Section 4, respectively, of the Form CMS-855A. If the attestation contains a different name, the contractor shall develop for the correct name.

(D) Date on Exhibit 177 - The contractor shall ensure that the date on which the Exhibit 177 was signed is on or after the date the FQHC listed as its effective date on the Form CMS-855A application. If the Exhibit 177 was signed prior to the listed effective date, the contractor shall (using the development procedures outlined in this chapter) develop for an Exhibit 177 signed on or after the FQHC's listed effective date; the FQHC should be providing services in order to meet the regulations noted in Exhibit 177.

(E) Date Application Complete - When reviewing an initial FQHC application, the contractor shall *determine* the date on which the FQHC's application was complete. To illustrate, assume that the FQHC submitted an initial application on March 1. Two data elements were missing, so the contractor requested additional information. The two elements were submitted on March 30. The contractor shall therefore indicate the March 30 date in its approval letter as the effective date of the FQHC.

(F) Site Visits - Site visits for FQHCs *may be* performed by HRSA prior to enrollment.

(G) Contractor Jurisdiction - Except for tribal and Urban Indian FQHCs, a freestanding FQHC that is initially enrolling is assigned to the Medicare Administrative Contractor (MAC) that covers the state in which the FQHC is located. An initially enrolling tribal or Urban Indian FQHC is assigned to the Jurisdiction H MAC.

(H) Tribal/Urban Indian Organizations – Certain outpatient health programs or facilities may be operated by a tribe or tribal organization or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act. The contractor shall confirm the applicant's attestation and tribal/urban Indian status if the FQHC indicates on the application that it has such status; several means are available:

- The applicable Indian Health Service (IHS) web link at https://www.ihs.gov/locations/. The contractor can search for the facility by clicking on the "Find Health Care" sub-link https://www.ihs.gov/findhealthcare/?CFID=15011511&CFTOKEN=36378825 or downloading the Excel complete listing of HIS facilities. (These are the highly recommended means of verification.)

- Contacting (1) the IHS directly, (2) contacting the applicable SOG Location, or (3) the contractor's PEOG BFL.

(I) Potential RHC Relationship – On occasion, a rural health clinic (RHC) may seek to convert to an FQHC. (A facility cannot be both an RHC and an FQHC.) Accordingly, in its review of an initial FQHC application, the contractor shall check PECOS to determine whether an RHC is enrolled at the same location. If one is, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov. In doing so, the contractor shall furnish to PEOG (1) the names, NPIs, and shared address of the RHC and FQHC, and (2) a copy of all information submitted with the FQHC application; the e-mail's subject line shall state: "RHC & FQHC shared address".

3. Determination

a. Approval

The contractor shall contact PEOG via email at MedicareProviderEnrollment@cms.hhs.gov if it believes that the FQHC's initial application should be approved. The contractor shall provide to PEOG: (1) a copy of the draft approval letter (see section 10.7.*5.1(N)* of this chapter for a model FQHC approval letter); (2) the Form CMS-855A application or PECOS Application Data Report (ADR) and all supporting documentation; (3) a copy of the FQHC's HRSA documentation; and (4) Exhibit 177.

While awaiting PEOG's final determination---and beginning on the date following the sending of the aforementioned e-mail---the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

b. Denial

If the contractor believes that the FQHC's application should be denied, the contractor shall notify the applicant of the denial using the appropriate model letter guidance in section 10.7.8 of this chapter. If the contractor is uncertain as to whether a denial is warranted or what the appropriate denial ground under 42 CFR 424.530(a) should be, it may contact its PEOG BFL for guidance.

4. Post-PEOG Review and Response to Contractor

If PEOG determines (based on the information the contractor furnished) that the FQHC's application should be approved, PEOG will:

- Assign the CCN, which will be part of the 1800-1989 series
- Assign the effective date, which will be the date the FQHC application was considered complete by the contractor
- Make any necessary revisions to the draft approval letter
- Sign and date the attestation using the completion date, which is also the effective date (Exhibit 177)
- E-mail all of the foregoing documents and data to the contractor, at which point the aforementioned processing time clock resumes.

5. Post-Approval Contractor Action

If PEOG notifies the contractor that the FQHC's application should be approved, the contractor shall send the approval letter to the FQHC with a copy of the signed Exhibit 177.

D. *Changes of Information*

1. Location Changes

a. Verification

If an FQHC is changing the physical location of an existing site, the FQHC must submit the following documentation (as applicable to that FQHC) to the contractor:

- For § 330 grantees, a Notice of Grant Award approving the physical location change and the new address; or

- For look-alikes, an updated letter from HRSA approving the physical location change and listing the new address.

(Consistent with the instructions in this chapter, the contractor shall develop for this documentation with the FQHC if the latter fails to submit it.)

For tribal/Urban Indian organizations, the contractor may confirm the new location via the IHS website or by contacting IHS. (See section 10.2.1.4(C)(2)(G) above for the web link.)

In all cases, the new address listed on the notice of grant award *(NOA)*, IHS website, etc., must match that listed on the Form CMS-855A change request. If it does not, the contractor shall develop with the FQHC for clarification consistent with the instructions in this chapter. *In addition, both the budget date and the project date on the NOA must be valid through the date on which the FQHC's change request application was complete (as determined by the contractor). The contractor shall develop for a correct NOA date(s) if the project period and/or budget period do not meet the aforementioned requirement.*

b. Approval

If approving the location change *or updating the contact information (as described in section 10.6.1.2 of this chapter),* the contractor does not issue a recommendation of approval to the SOG Location, notwithstanding any instruction to the contrary in this chapter; rather, the contractor shall approve the location change in PECOS and issue an approval letter to the FQHC (with an e-mailed copy to PEOG at MedicareProviderEnrollment@cms.hhs.gov *(Subject line: FQHC COI—Address Change/Contact Change/Other).* PEOG will update ASPEN accordingly.). Beginning on March 15, 2021, tie-in notices will not be issued for address changes.

c. Denial

If the contractor does not approve the location change (i.e., the FQHC is no longer located in a shortage area, the FQHC fails to submit the applicable HRSA supporting documentation after contractor development (discussed above), or another reason is implicated), the contractor shall refer the matter to PEOG at ProviderEnrollmentRevocations@cms.hhs.gov consistent with all applicable instructions in this chapter and other CMS directives. (The referral shall include, at a minimum, the FQHC's LBN and NPI as well as a brief explanation of the situation and the reason for referral.) PEOG will review the matter and instruct the contractor on how to proceed.

2. LBN, TIN, or DBA Name Changes Not Involving a CHOW

The contractor shall process LBN, TIN, or DBA name changes not involving a CHOW consistent with the instructions in sections 10.6.1.2(B)(1) and (3) of this chapter. No notification to the state or SOG Location regarding the change is needed.

3. All Other Change Requests

For all change requests not described in subsections (D)(1) and (2) above, the contractor shall follow the instructions in sections 10.6.1.2(C)(1) and (2) of this chapter.

E. Changes of Ownership (CHOWs)

This section 10.2.1.4(E) addresses procedures for processing FQHC CHOWs. Except as noted otherwise, these instructions take precedence over those in section 10.6.1.1.3 et seq. of this chapter.

For background information on CHOWs (which, for purposes of section 10.2.1.4(E), includes acquisitions/mergers and consolidations) and potential CHOW situations, see sections 10.6.1.1.1 and 10.6.1.1.2 of this chapter. The contractor shall, as needed, refer to these instructions in examining whether a CHOW has occurred. In reviewing said sections, the contractor shall note the following:

- *The "provider agreement" for FQHCs is the Exhibit 177.*
- *No recommendations to the state or SOG Location are involved. The contractor and PEOG alone will handle the transaction. In particular, the contractor---in lieu of making a recommendation to the state/SOG Location---will send its "final analysis" to PEOG. PEOG will then: (i) review the transaction; (ii) determine whether the CHOW should be approved; (iii) as needed, update ASPEN and perform any other related tasks; and (iv) notify the contractor of the results of its review and provide any required direction. The aforementioned process, in effect, combines a recommendation to the state/SOG Location and the contractor's post-recommendation e-mail to PEOG (described in section 10.6.1.1.3.3(B)) into a single step. For purposes of this section 10.2.1.4(E), the term "final analysis" (in the context of FQHC CHOWs) is roughly the equivalent of a recommendation to the state. Accordingly, when sending its "final analysis" to PEOG as described above, the contractor may—but is not required to—change the application's status in PECOS to "approval recommended."*

In addition---and except as otherwise stated---the contractor shall adhere to the following subsections and instructions in sections 10.6.1.1.3 et seq. and 10.6.1.1.4:

(i) Section 10.6.1.1.3.1(A) (This does not include the list of documents in section 10.6.1.1.3.1(A)(iii), although all other instructions in section 10.6.1.1.3.1(A)(iii) shall be followed (e.g., development for missing/deficient documents). The required FQHC CHOW documents are identified in this section 10.2.1.4(E).)

(ii) Section 10.6.1.1.3.1(B) (Regarding section 10.6.1.1.3.1(B)(4), the contractor shall make this referral to PEOG before (and separate from) sending its final analysis to PEOG.)

(iii) Sections 10.6.1.1.3.1.1(A)(1), (A)(2), (A)(3), (B)(1), (B)(2), (B)(3)(a) and (c), (F), and (G). (The contractor can disregard references to state recommendations in these sections.) The remaining topics/instructions in section 10.6.1.1.3.1.1 are either inapplicable to FQHC CHOWs or addressed in this section 10.2.1.4(E).

(iv) Sections 10.6.1.1.4(A), (B), (C), (D), (E), (F), (G), and (H) (With respect to the application of 10.6.1.1.4(C) to FQHC CHOWs, receipt of an approval recommendation from the state (as described in 10.6.1.1.4(C)) is the equivalent of the contractor sending its final analysis to PEOG.)

The following instructions address FQHC-specific CHOW processing activities that the contractor shall follow in addition to the procedures contained in the section 10.6.1.1 et seq. subsections outlined in (i) through (iv) above. If any inconsistency exists between these two sets of instructions (i.e., recommending approval to the state as described in 10.6.1.1 et seq. versus making a final analysis to PEOG as described below), the latter takes precedence.

1. Special Processing Steps

a. <u>Required Documents</u> – The contractor shall ensure that the FQHC submits all documentation otherwise required per this chapter. For FQHC CHOW purposes, this also includes:

- *Legal Documentation of CHOW - The legal documents that governed the transaction, such as a sales agreement, bill of sale, or transfer agreement. (See section 10.6.1.1.3.1.1(B) for more information on such documents.)*

- *Evidence of state licensure of the new entity, if applicable. (This can be furnished consistent with existing instructions in this chapter concerning submission of evidence of state licensure.)*

- *Exhibit 177 containing the new owner's information.*

- *HRSA NOA or FQHC Look-Alike Designation containing the new owner's information. (NOTE: Both the budget date and the project date on the NOA must be valid through the date on which the FQHC's CHOW application was complete (as determined by the contractor). The contractor shall develop for a correct NOA date(s) if the project period and/or budget period do not meet the aforementioned requirement.)*

b. Old and New Owner Applications

i. Order of Receipt - To the maximum extent practicable, FQHC CHOW applications from the previous and new owners should be processed as they arrive.

ii. Non-Receipt of Previous Owner's Application – Although the contractor shall attempt to collect the old owner's application, it may make its final analysis without it.

c. Relocation of Entity - A new owner may seek to relocate the FQHC concurrent with a CHOW. In such cases, the contractor shall ensure that the FQHC submits (along with the documents in (E)(1)(a) above):

- *For § 330 grantees, a Notice of Grant Award approving the physical location change and the new address; or*
- *For look-alikes, an updated letter from HRSA approving the physical location change and listing the new address.*

For tribal/Urban Indian organizations, the contractor may confirm the new location via the IHS website or by contacting IHS. (See section 10.2.1.4(C)(2)(H) above for the web link.)

The new address listed on the notice of grant award, IHS website, etc., must match that on the Form CMS-855A CHOW application. If it does not, the contractor shall develop with the FQHC for clarification consistent with the instructions in this chapter.

Notwithstanding the foregoing, the entire transaction shall be processed as a CHOW rather than a COI.

d. Intervening Change of Ownership

In situations where the FQHC (1) submits a Form CMS-855 initial application or CHOW application and (2) subsequently submits a Form CMS-855 CHOW application, the contractor shall adhere to the following:

Situation 1 – The FQHC submitted an initial application followed by a CHOW application, and the contractor has not yet sent its final analysis to PEOG: The contractor shall return both applications and require the FQHC to re-submit an initial application with the new owner's information.

Situation 2 - The FQHC submitted a CHOW application followed by another CHOW application, and the contractor has not yet sent its final analysis to PEOG regarding the first application: The contractor shall process both applications, preferably in the order they were received. When sending its final analysis to PEOG, the contractor shall explain the dual CHOW application submission.

Situation 3 - The FQHC submitted an initial application followed by a CHOW application, and the contactor has sent its final analysis of the initial application to PEOG but before it has notified the FQHC of the approval of the initial application: The contractor shall:

- *Return the CHOW application.*

- *Notify PEOG via e-mail that a change of ownership has occurred (the new owner should be identified) and that the contractor will require the FQHC to resubmit a new initial application containing the new owner's information.*

- *Request via letter that the FQHC submit a new initial Form CMS-855 application containing the new owner's information within 30 days of the date of the letter. If the FQHC fails to do so, the contractor shall return the originally submitted initial application and notify the FQHC accordingly. If the FQHC submits the requested application, the contractor shall process it consistent with the instructions in this chapter; the originally submitted initial application becomes moot. If the newly submitted/second initial application is denied, however, the first submitted application is denied as well; the contractor shall notify the FQHC accordingly.*

Situation 4 - The FQHC submitted a CHOW application followed by another CHOW application, and the contactor has sent its final analysis of the first CHOW application to PEOG but before it has notified the FQHC of the approval thereof - The contractor shall:

- *Notify PEOG via e-mail that (1) a subsequent change of ownership has occurred (the new owner should be identified) and (2) the contractor will require the FQHC to resubmit a new CHOW application containing the subsequent/second new owner's information.*

- *Process the new/second CHOW application as normal. If a final analysis to PEOG is made for this application, the contractor shall explain this situation in its e-mail; the first CHOW application becomes moot. If the newly submitted/second CHOW application is returned or rejected per the instructions in this chapter, the first application should, too, be returned or rejected (as applicable). The contractor shall notify the provider and PEOG accordingly.*

2. Post-Initial Review Actions and Scenarios

After the contractor completes the tasks described in the above-referenced sections, several results are possible. These are discussed below. Should the contractor encounter a scenario not addressed herein, it may contact its PEOG BFL for guidance prior to its final analysis. As a reminder, nothing in this section 10.2.1.4(E)(2) prohibits the contractor from returning or rejecting the application if otherwise permitted to do so per this chapter.

a. The contractor ascertains that the transaction falls within the scope of § 489.18 and that the new owner has accepted assignment – If there are no apparent grounds for denying the CHOW application, the contractor shall send its final analysis to PEOG via e-mail at MedicareProviderEnrollment@cms.hhs.gov with the following information and documents: (1) the Form CMS-855 application or PECOS Application Data Report; (2) a copy of the final sales/transfer agreement; (3) a copy of the provider-signed Exhibit 177; and (4) NOA. PEOG will countersign the Exhibit 177 and assign an effective date of the CHOW based on

the date the application was complete (as determined by the contractor). Within 5 business days of receiving from PEOG the signed Exhibit 177 and effective date, the contractor shall: (1) send the CHOW approval letter and a copy of the CMS-countersigned Exhibit 177 to the FQHC; and (2) switch the PECOS record to "approved" consistent with existing instructions.

If a denial ground exists, however, the contractor shall refer the matter to its PEOG BFL for guidance notwithstanding any other instruction in this chapter to the contrary. The contractor should include an explanation of the ground(s) it believes exists for the denial (including the regulatory citation); the e-mail referral shall state in the subject line "FQHC Guidance Required."

b. The contractor ascertains that the transaction falls within the scope of § 489.18 but the new owner has not accepted assignment – The contractor shall: (a) return the application; and (b) notify the new owner in the return letter that it must submit the following within 30 days from the date of the return letter: (1) an initial Form CMS-855 application to enroll as a new FQHC; and (2) a voluntary termination application for the existing FQHC. If the new owner fails to do so within 30 days of the request, the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter. PEOG will review the matter and respond to the contractor.

c. The contractor ascertains that the transaction does not fall within the scope of § 489.18 (e.g., stock transfer), regardless of whether the new owner accepted assignment - This qualifies as an ownership change under 42 CFR § 424.516 rather than a CHOW under § 489.18. The contractor shall: (A) return the application; and (B) notify the FQHC in the return letter that it must submit a Form CMS-855 application to report the ownership change within 30 days of the return letter and provide all supporting documentation (including a revised NOA and agreement). If the provider fails to do so, the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter.

F. Timeframes and Alternatives

While awaiting PEOG's final determination (and beginning on the date following the sending of the aforementioned e-mail) *for the applications described in subsections (C), (D), and (E),* the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's decision. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock. In addition, nothing in this section 10.2.1.4 negates other processing alternatives outlined in this chapter that can apply to the processing of FQHC applications.

G. Revocations and Other Transactions

Except as otherwise stated or required by CMS, the contractor shall continue to adhere to the applicable instructions in this chapter and all other CMS directives regarding:

- Potential FQHC revocations and referrals (including sending the referral/information to the appropriate PEOG mailbox)
- Changes of ownership
- Changes of information
- Revalidations
- Reactivations

Upon revalidation or reactivation, an FQHC need not submit a new HRSA Notice of Award (NoA) (unless HRSA made an update and issued the FQHC a new one) or new Exhibit 177; new provider agreements are not required for either transaction.

H. Complaint Investigations

CMS SOG Locations investigate complaints that raise credible allegations of an FQHC's noncompliance with health and safety standards found at 42 CFR 405 Subpart X, and 42 CFR 491 Subpart A (except for 42 CFR § 491.3). The contractor shall refer such complaints to the SOG Location that has jurisdiction over the FQHC.

For additional general information on FQHCs, refer to:

- Section 1861(aa)(3-4) of the Social Security Act
- 42 CFR Part 491 and 42 CFR Part 405, subpart X
- Pub. 100-07, chapter 2, sections 2825 – 2826H
- Pub. 100-07, chapter 9, exhibits 177 and 179
- Admin Info 21 06-ALL – Transitioning FQHC Certification Enrollment Performed by the CMS SOG (Standard Operating Procedures attached)
- Pub. 100-04, chapter 9
- Pub. 100-02, chapter 13

For additional information on the appropriate contractor jurisdictions for incoming FQHC enrollment applications, see Pub. 100-04, chapter 1, section 20 as well as Pub. 100-07, chapter 9, exhibit 179.

10.2.1.8 - Hospitals and Hospital Units

(Rev. 11307; Issued: 03- 25- 2022; Effective:03-04-22; Implementation: 04-25-22)

A. General Background Information

Hospitals and hospital units are a provider type that enrolls via the Form CMS-855A. An exception to this is when the hospital is requesting enrollment to bill for practitioner services for hospital departments, outpatient departments, outpatient locations, and/or hospital clinics; in this circumstance, a new Form CMS-855B enrollment application is required.

B. Enrollment Information

1. Swing-Bed Designation

A "swing-bed" hospital is one that is approved by CMS to furnish post-hospital skilled nursing facility (SNF) services. That is, hospital (or critical access hospital (CAH)) patients' beds can "swing" from furnishing hospital services to providing SNF care without the patient necessarily being moved to another part of the building. It receives a separate survey and certification from that of the hospital. Thus, if swing-bed designation is terminated, the hospital still maintains its certification. In addition, the hospital is given an additional CCN to bill for swing-bed services. (The third digit of the CCN will be the letter U, W, Y or Z.)

In general, and as stated in 42 CFR § 482.58, in order to obtain swing-bed status the hospital must, among other things: (1) have a Medicare provider agreement; (2) be located in a rural area; and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs, and the hospital is thus used to furnish SNF services.

A separate provider agreement and enrollment for the swing-bed unit is not required. (The hospital's provider agreement incorporates the swing-bed services.) The hospital can add the swing-bed unit as a practice location via the Form CMS-855A.

Additional data on "swing-bed" units can be found in Pub. 100-07, chapter 2, sections 2036 – 2040.

2. Psychiatric and Rehabilitation Units

Though these units receive a state survey, a separate provider agreement and enrollment is not required. (The hospital's provider agreement incorporates these units.) The hospital can add the unit as a practice location to the Form CMS-855A.

3. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

4. Physician-Owned Hospitals

As defined in 42 CFR § 489.3, a physician-owned hospital (POH) means any participating hospital (as defined in 42 CFR §489.24) in which a physician or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. (This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR § 411.356(a) or (b).)

Section 2(A)(4) of the Form CMS-855A asks the applicant to identify whether it is a physician-owned hospital. If the applicant indicates in Section 2(A)(2) that it is a hospital, it must complete Section 2(A)(4). Applicants that are not hospitals need not complete Section 2(A)(4).

At this time, POHs are not required to submit a completed Form CMS-855POH or a completed Attachment 1 of the Form CMS-855A. As stated in the March 12, 2015 announcement in MLN Connects Provider eNews, CMS has extended the deadline for the POH Initial Annual Ownership/Investment Report due to concerns about the accuracy of the data collected in the report. Future instruction regarding the reporting of POH ownership and investment will be provided on the CMS physician self-referral website.

5. Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. CAHs instead must be enrolled as a separate, distinct provider type. Thus, if an existing hospital wishes to convert to a CAH, it must submit a Form CMS-855A as an initial enrollment.

6. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

If the contractor makes a recommendation for approval of the provider's request to add a hospital unit, the contractor shall forward the package to the state agency as described in this chapter.

7. Transplant Programs

For purposes of Medicare enrollment, a hospital transplant program is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant program, it must check the "other" box in Section 2A2 of the Form CMS-855A, write "transplant program*" (and the type(s) thereof, such as liver transplant program, kidney transplant program, etc.)* on the space provided, and follow the standard instructions for adding a *hospital* sub-unit*. (If multiple types of transplant programs are listed, the contractor shall (a) treat each as a separate sub-unit for enrollment purposes and (b) process the application in the same fashion it would a hospital application that is reporting/adding multiple sub-units.) N*o separate enrollment in PECOS need be created for the transplant center.

C. Other Enrollment Procedures

Regarding Section 4 of the Form CMS-855A, the hospital 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 hospital'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. 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 an enrolled hospital seeks to add a rehabilitation, psychiatric, or swing-bed unit, it should submit a Form CMS-855 change of information request and not an initial enrollment application.

D. Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals

Non-participating emergency hospitals, VA hospitals and DOD hospitals no longer need to complete a Form CMS-855A enrollment application in order to bill Medicare.

E. Form CMS-855B Applications Submitted by Hospitals

1. Group Practices

If an entity is enrolling via the Form CMS-855B as a hospital-owned clinic/physician practice, the contractor shall contact the applicant to determine whether the latter will be billing any of the listed locations as provider-based. If the applicant will not be billing as provider-based, the contractor shall process the application normally. If, however, the applicant will bill as provider-based, the contractor shall notify the applicant that the hospital must report any changed practice locations to its contractor via the Form CMS-855A.

If the supplier is enrolling as a hospital department (under the "Clinic/Group Practice" category on the Form CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the contractor shall only issue the necessary billing numbers upon notification that a provider agreement has been issued – or, in the case of a CHOW, the provider agreement has been transferred to the new owner. If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), the contractor need not wait until the provider agreement is issued before conveying billing privileges to the group.

2. Individual Billings

Assume an individual physician works for a hospital and will bill for services as an individual (i.e., not as part of the hospital service/payment). However, he/she wants to reassign these benefits to the hospital. The hospital will need to enroll with the contractor via the Form CMS-855B (e.g., as a hospital department, outpatient location).

10.2.4 - Other Medicare Part B Services

(Rev. 11307; Issued: 03- 25- 2022; Effective:03-04-22; Implementation: 04-25-22)

A. Residents and Interns

1. General Background Information

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

The physician should indicate the exact date *on which* its residency program, internship, or fellowship was completed, so that the appropriate effective date can be issued.

2. Interns are Ineligible to Enroll in the Medicare Program

An intern cannot enroll in the Medicare program. (For purposes of this requirement, the term "intern" means an individual who is not licensed by the *s*tate because he/she is still in post-graduate year (PGY) 1.)

B. Diabetes Self-Management Training

Diabetes self-management training (DSMT) is not a separately recognized provider type, such as a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. Rather, DSMT is an extra service that an enrolled provider or supplier can bill for, assuming it meets all of the necessary DSMT requirements. If the person or entity enrolls as a provider type (i.e., pharmacy, mass immunizer) that requires the submission of an application fee, the fee shall be submitted with the application.

All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization. CMS recognizes the American Diabetes Association (ADA) and the Association of Diabetes Care & Education Specialists (ADCES) (formerly known as the American Association of Diabetes Educators or AADE) as approved national accreditation organizations. A Medicare-enrolled provider or non-DMEPOS supplier that wishes to bill for DSMT may simply submit the appropriate accreditation certificate to its contractor. No Form CMS-855 is required unless the provider or supplier is not in the Provider Enrollment, Chain and Ownership System (PECOS), in which case a complete Form CMS-855 application must be submitted.

If the supplier is exclusively a DMEPOS supplier, it must complete and submit a Form CMS-855B application to its local Part A/B MAC. This is because A/B MACs, rather than Durable Medical Equipment Medicare Administrative Contractors, pay DSMT claims. Thus, the DMEPOS supplier must separately enroll with its A/B MAC even if it has already completed a Form CMS-855S. If an A/B MAC receives an application from a DMEPOS supplier that would like to bill for DMST, it shall verify with the National Supplier Clearinghouse that the applicant is currently enrolled and eligible to bill the Medicare program.

For more information on DSMT, refer to:

- 42 CFR Part 410 (subpart H)

- Publication 100-02, Medicare Benefit Policy Manual, chapter 15, sections 300 – 300.5.1

C. Mass Immunizers Who Roster Bill

An entity or individual who wishes to furnish mass immunization services - but may not otherwise qualify as a Medicare provider - may be eligible to enroll as a "Mass Immunizer" via the Form CMS-855I (individuals) or the Form CMS-855B (entities). Such suppliers must meet the following requirements:

1. They may not bill Medicare for any services other than pneumococcal pneumonia vaccines (PPVs), influenza virus vaccines, and their administration.

2. They must submit claims through the roster billing process.

3. The supplier, as well as all personnel who administer the shots, must meet all applicable state and local licensure or certification requirements.

The roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by public health clinics and other organizations.

In addition:

- *See* 42 CFR §§ 424.520(d) *and 424.521(a) for information regarding mass immunizer effective dates.*

- In *S*ection 4 of the Form CMS-855, the supplier need not list each off-site location (e.g., county fair, shopping mall) at which it furnishes services. It need only list its base of operations (e.g., county health department headquarters, drug store location).

For more information on mass immunization roster billing, refer to:

- Publication 100-02, Benefit Policy Manual, chapter 15, section 50.4.4.2

- Publication 100-04, Claims Processing Manual, chapter 18, sections 10 through 10.3.2.3

D. Advanced Diagnostic Imaging

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act. It required the Secretary to designate organizations to accredit suppliers – including, but not limited to, physicians, non-physician practitioners, and independent diagnostic testing facilities - that furnish the technical component (TC) of advanced diagnostic imaging services. MIPPA specifically defin*ed* advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, such as positron emission tomography (PET). The law also authorizes the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

CMS *has* approved four national accreditation organizations (AOs) – the American College of Radiology, the Inter-societal Accreditation Commission, the Joint Commission, and Rad Site - to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation appl*ies* only to*: (1)* the suppliers of the images, not to the physician's interpretation of the image*; and (2)* those who are paid under the Physician Fee Schedule. All *AOs* have quality standards that address the safety of the equipment as well as the safety of the patients and staff. Each of these designated AOs submits monthly reports to CMS that list the suppliers who have been or are accredited, as well as the beginning and end-date*s* of the accreditation and the respective modalities for which they receive accreditation.

Newly enrolling physicians and non-physician practitioners described above do not need to complete the appropriate boxes for Advanced Diagnostic Imaging (ADI) on Internet-based PECOS or the appropriate *Form* CMS-855. Information for all ADI accredited suppliers is provided to CMS *by* the approved ADI *AOs.* The contractor need not verify ADI information *submitted* on the application.

10.2.6 - Medicare Diabetes Prevention Program (MDPP) Suppliers

(Rev. 11307; Issued: 03- 25- 2022; Effective: 03-04-22; Implementation: 04-25-22)

A. General Background Information

MDPP is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. An entity or individual *seeking* to furnish MDPP services to Medicare beneficiaries must enroll as an "MDPP supplier" via the Form CMS-20134. Such suppliers must meet the following *enrollment* requirements:

- Ha*s* MDPP preliminary recognition *(*as defined at 42 CFR *§* 424.205*(c)(1))* or full recognition as determined by the Center for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP)

- *M*aintain*s a* valid TIN and NPI at the organizational level

- Passed screening *requirements* at a high categorical risk level per § 424.518(c) upon initial enrollment and revalidate at *the* moderate categorical risk level per § 424.518(b) and

- Complies with the supplier standards

MDPP supplier applicants do not require any licensure, accreditation, or certificates to be eligible to enroll as an MDPP supplier. Rather, the CDC administers the curriculum for the MDPP and monitors the organization's fidelity to and success with furnishing the services. Thus, organizations with preliminary or full recognition from the CDC's DPRP indicate that they are prepared to deliver MDPP services.

As a part of the expanded CMMI model, CMS will only accept in-person MDPP suppliers to enroll in Medicare. Though an entity may furnish a select number of virtual MDPP make up sessions to a beneficiary (no more than 4 per beneficiary over the entire period of MDPP services), they would still be considered in-person MDPP suppliers.

B. MDPP Supplier Standards

All MDPP suppliers must comply with MDPP supplier standards to obtain and retain Medicare billing privileges. Consistent with 42 CFR § 424.205*(b)(5) and* (d), each MDPP

*s*upplier must certify on its Form CMS-20134 enrollment application that it meets and will continue to meet the following standards (listed in § 424.205*(d))* and all other requirements:

(1) Must have and maintain MDPP preliminary recognition or full CDC DPRP recognition
(2) Must not currently have its billing privileges terminated or be excluded by a state Medicaid agency
(3) Must not permit MDPP services to be furnished by or include on its roster any individual coach who meets *the* ineligibility criteria *in § 424.205(e)(1)*
(4) Must maintain at least one administrative location on an appropriate site. All administrative locations, must be reported on their CMS-20134 form and may be subject to site visits. *(See § 424.205(d)(4) for more information regarding site requirements.)*
(5) Must update th*e* enrollment application within 30 days for any changes of ownership, changes to the coach roster, and final adverse legal action history*,* and update all other changes within 90 days
(6) Must maintain a primary business telephone that is operating at administrative locations or directly where services are furnished. The associated telephone number must be listed with the name of the business in public view.
(7) Must not convey or reassign a supplier billing number
(8) Must not deny an MDPP beneficiary access to MDPP services during the MDPP benefit period, including conditioning access to MDPP services on the basis of an MDPP beneficiary's weight, health status, or achievement of performance goals *(*with certain ex*ce*ptions *described in § 424.205(d)(8)(i))*
(9) Must not---nor may other individuals or entities performing functions or services related to MDPP services on the MDPP supplier's behalf---directly or indirectly commit any act or omission, or adopt any policy that coerces or otherwise influences an MDPP beneficiary's decision to begin accessing MDPP services or change to a different MDPP supplier specifically
(10) Must offer an MDPP beneficiary no fewer than the services described in *§ 424.205(d)(10)*
(11) Must disclose detailed information about the MDPP benefit to each beneficiary to whom it furnishes MDPP services before the initial core session is furnished, including the set of services, eligibility requirements, the once-per-lifetime nature of MDPP *services*, and the standards *in § 424.205(d)*
(12) Must answer MDPP beneficiaries' questions about MDPP services and respond to MDPP related complaints. An MDPP supplier must implement a complaint resolution protocol and maintain documentation of all beneficiary contact regarding such complaints, including the name and Medicare Beneficiary Identifier of the beneficiary, a summary of the complaint, related correspondences, notes of actions taken, and the names and/or NPIs of individuals who took such action on behalf of the MDPP supplier. This information must be kept at each administrative location and made available to CMS or its contractors upon request
(13) Must maintain a crosswalk file which indicates how participant identifications for the purposes of CDC performance data correspond to corresponding beneficiary health insurance claims numbers or Medicare Beneficiary Identifiers for each MDPP beneficiary. The MDPP supplier must submit the crosswalk file to CMS or its contractor
(14) Must submit performance data for MDPP beneficiaries who attend ongoing maintenance sessions with data elements consistent with the CDC's DPRP *s*tandards for data elements required for the core benefit
(15) Must allow CMS or its agents to conduct onsite inspections or recordkeeping reviews in order to ascertain the MDPP supplier's compliance with these standards, as well as *the* documentation requirements outlined *§ 424.205(g)*

The CMS will notify *the* contractor when an MDPP supplier within *its* jurisdiction has moved from preliminary or full recognition down to pending and therefore no longer maintains eligibility *as* an MDPP supplier.

For those suppliers that no longer have a valid recognition level to maintain their MDPP supplier enrollment, the contractor shall take the necessary steps to revoke the supplier's billing privileges.

Violations of *the supplier* standards are determined as non-compliance and the associated enrolment denial and revocation authorities would apply.

10.2.8 - Providers/Suppliers Not Eligible to Enroll

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

Below is a list of individuals and entities that frequently attempt to enroll in Medicare but are not eligible to do so. *(*This list is not all-inclusive*, however.)*. If the contractor receives an enrollment application from any of these individuals or entities, the contractor shall deny the application -- with the exception of entities eligible to enroll using the Form CMS-20134, which is specific to the furnishing of MDPP services*. A*n assisted living facility, for example, that also provides the DPP and is eligible to enroll as an MDPP supplier may enroll through the CMS-20134*;* however, this enrollment only pertains to the rendering of MDPP services.

- Acupuncturist
- Assisted Living Facility
- Birthing Center
- Certified Alcohol and Drug Counselor
- Certified Social Worker
- Drug and Alcohol Rehabilitation Counselor
- Hearing Aid Center/Dealer
- Intern (Graduate Medical Education)
- Licensed Alcoholic and Drug Counselor
- Licensed Massage Therapist
- Licensed Practical Nurse
- Licensed Professional Counselor
- Marriage Family Therapist
- Master of Social Work
- Medicare Beneficiaries
- Mental Health Counselor
- National Certified Counselor
- Naturopath
- Occupational Therapist Assistant
- Physical Therapist Assistant
- Registered Nurse
- Speech and Hearing Center
- State Medicaid Agency (*SMA)(SMAs* do not have an *NPI* and are not eligible to enroll in the Medicare program. If *an SMA* is enrolled or seeks enrollment as a provider or supplier in the Medicare program, the contractor shall deny or revoke its Medicare billing privileges using, respectively, § 424.530(a)(5)(*ii*) (denials) and § 424.535(a)(*5)(ii*) (revocations) as the basis.*)*
- Substance Abuse Facility

10.4.2.3 – Additional Denial Policies

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Post-Denial Submission of Enrollment Application

A denied provider may not submit a new enrollment application until:

(i) If the initial denial was not appealed, the provider's appeal rights have lapsed;

(ii) If the initial denial was appealed, the provider has received notification that the determination was upheld; or

(iii) The reapplication bar has expired, if applicable.

The contractor shall return an application submitted before the aforementioned have occurred.

B. 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 or administrative or management personnel of the provider or supplier furnishing services payable by a federal health care program, the denial may be reversed (with PEOG approval) if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

C. Denials - Changes of Information and Changes of Ownership (CHOWs)

1. Expiration of Timeframe for Reporting Changes

If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to the CMS MedicareProviderEnrollment@cms.hhs.gov mailbox notifying PEOG of the denial. PEOG will determine whether the provider's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.

2. Timeframe Not Yet Expired

If the contractor denies 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 referenced in subsection (C)(1) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

3. Second Rejection, Return, or Denial

If, per subsection (C)(2) above, the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it, or rejects it, the contractor shall send the e-mail referenced in subsection (C)(1) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.

D. Reactivations

If the contractor denies a reactivation application, the provider's Medicare billing privileges shall remain deactivated or revoked.

E. Revalidations

If the contractor denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive states otherwise - deactivate the provider's Medicare billing privileges 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, per the previous sentence, the provider resubmits the application and the contractor denies it again, returns it, or rejects it, the contractor shall - unless an existing CMS instruction or directive states otherwise – revoke the provider's billing privileges, assuming the applicable time period has expired.

F. Appeals of Denials

For information regarding the provider enrollment appeals process, see section 10.6.18 of this chapter.

G. (A)(1) Versus (A)(5)

In cases where denial is warranted because the provider/supplier's location is vacant, occupied by another party, closed during office hours, etc., or a state survey failure is involved, the contractor shall use § 424.530(a)(5) (rather than § 424.530(a)(1)) as the denial reason. (This applies to both certified and non-certified providers/suppliers.) No CAP rights are therefore involved.

10.4.3 – Voluntary and Involuntary Terminations

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Voluntary Terminations of Certified Providers and Certified Suppliers

For information regarding certified provider/supplier voluntary terminations, see section 10.6.1.3 of this chapter.

B. Voluntary Terminations of Non-Certified Suppliers

The contractor shall adhere to the following when processing voluntary terminations of non-certified suppliers.

1. Timeframes – The contractor shall process such voluntary terminations in accordance with the timeframes in section 10.5 et seq. of this chapter.

2. Submission – Non-certified suppliers may only submit voluntary termination requests via the paper or Internet-based Form CMS-855/20134. They cannot do so via letter.

3. Reassignments/PTANs - When processing a voluntary termination of a reassignment, the contractor shall contact the group to confirm that: (1) the group member PTAN is being terminated from all locations; and (2) if multiple group member PTANs exist for multiple group locations, each PTAN is terminated. However, if a group has one PTAN with multiple addresses, the contractor need not contact the group to confirm the termination.

When processing a voluntary termination of a reassignment, the contractor shall terminate non-certified suppliers effective the day after that which the supplier requested on its termination application.

4. Special Payments - Upon receipt of a non-certified supplier voluntary termination request, the contractor may ask the supplier to complete the "Special Payments" portion of Section 4 of the Form CMS-855/20134 so that future payments can be sent thereto. If the supplier has no special payments address already on file, the addition should be included in the same transaction as the termination (i.e., one transaction incorporating both items). If the supplier wants to change its existing special payments address, the transaction should be treated as a separate change request (i.e., one termination and one change request). The supplier is not required to submit a Form CMS-588 in conjunction with a termination.

C. Involuntary Terminations – Certified Providers/Suppliers

In the event an instruction in section 10.6.1 et seq. of this chapter contradicts guidance in this section 10.4.3(C), the section 10.6.1 et seq. guidance takes precedence.

1. Notification from State or SOG Location

If the contractor receives a notice from the state or SOG Location that involuntarily terminates a certified provider/supplier's Medicare participation because the provider/supplier no longer meets the conditions of participation, the contractor need not send a letter to the provider/supplier stating that its Medicare participation has been terminated. The state or SOG Location will issue such a letter and afford appeal rights. The contractor shall follow the applicable instructions in section 10.4.7 et seq. of this chapter with respect to revoking the provider/supplier's enrollment, since the provider/supplier is no longer compliant with Medicare enrollment regulations. **(NOTE:** The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) with which the provider/supplier is non-compliant.)

The contractor shall record the revocation in PECOS using the status reason of "Non-Compliance: Provider/Supplier Type Requirements Not Met." The contractor shall not identify the involuntary termination action in PECOS as a Deactivation with a status reason of "Voluntarily Withdrawal from the Medicare Program." In addition, the contractor shall end-date the entity's enrollment record in PECOS in the same manner as it would upon receipt of a termination notice from the SOG Location.

2. Revocation Letter

Per subsection (C)(1) above, the contractor shall issue a revocation letter to the certified provider/supplier using 42 CFR § 424.535(a)(1) as the legal basis for the revocation. The letter shall also contain the effective date of the revocation, appeal rights, and the length of the reenrollment bar as determined by CMS and indicated to the contractor. (See section 10.7 et seq. of this chapter for the applicable revocation letter.) The contractor shall e-mail a copy of the letter to the SOG Location using the same e-mail address it normally uses when communicating with the SOG Location's survey and certification staff.

3. Additional Information

For more information on voluntary terminations, refer to:

- Section 1866(b)(1) of the Social Security Act
- 42 CFR § 489.52(b)
- Pub. 100-07, chapter 3, section 3046 (SOM)

10.4.4 – Changes of Information

(Rev. 11307; Issued: 03- 25-2022; Effective:03-04-22; Implementation: 04-25-22)

A. General Information

Unless as stated otherwise in this chapter, the following apply:

(i) The instructions in this section 10.4.4 apply to Part A and Part B enrollments.

(ii) In the event an instruction in section 10.6.1 et seq. of this chapter contradicts that in this section 10.4.4, the section 10.6.1 et seq. guidance takes precedence (e.g., certified provider/supplier change of information instructions in section 10.6.1.2 of this chapter).

(iii) Except as otherwise specified in this chapter or another CMS directive, if an enrolled provider/supplier is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855 or CMS-20134. (Letterhead is impermissible.) The provider/supplier shall: (a) furnish the changed data in the applicable section(s) of the form; and (b) sign and date the certification statement.

(iv) The timeframes for reporting changes are generally addressed in § 424.516.

B. Time Requirements to Report Changes of Information via a Form CMS-855/20134 Application

1. Physicians/Non-Physicians/Groups

Pursuant to § 424.516(d), change of information requirements apply to physicians, non-physician practitioners, and physician and non-physician practitioner organizations (i.e., clinic/group practices). These supplier types must report the following changes within 30 days: (1) a change of ownership; (2) adverse legal action; and (3) a change in practice location. All other changes must be reported within 90 days.

2. DMEPOS Suppliers

Per 42 CFR §§ 424.57(c)(2) and 424.516(c), DMEPOS suppliers must report any change to their enrollment information within 30 days.

3. IDTFs

Per 42 CFR §§ 410.33(g)(2) and 424.516(b), IDTFs must report any change in adverse legal actions, ownership, location, and general supervision within 30 days. All other changes must be reported within 90 days.

4. MDPP Suppliers

Per 42 CFR §§ 424.205(d)(5) and 424.516(e), an MDPP supplier must update its enrollment application within 30 days of any change of ownership, change to its coach roster (including due to coach ineligibility or because the coach is no longer an employee, contractor, or volunteer of the MDPP supplier), or change in final adverse action history. All other changes must be reported within 90 days.

5. All Other Provider/Supplier Types

Consistent with 42 CFR § 424.516(e), all other provider/supplier types not specifically referenced in § 424.516(b) through (e) are subject to the following reporting timeframes:

(i) Changes of ownership or control (including changes in authorized official(s) or delegated official(s)) – 30 days

(ii) All other changes – 90 days

(In addition, and per § 424.516(e)(3), an air ambulance supplier must report a revocation or suspension of its license or certification to the contractor within 30 days of the revocation/suspension. The following FAA certifications must be reported: (a) specific pilot certifications including, but not limited to, instrument and medical certifications; and (b) airworthiness certification.)

C. Signatories and Notifications

1. Signer Not on Record - If the signer has never been reported in Section 6 of the Form CMS-855 or CMS-20134, Section 6 must be completed in full with information about the individual. (This policy applies regardless of whether the provider/supplier already has a Form CMS-855/20134 on file.) The contractor shall conduct all required validations concerning the individual.

2. Notifications – For changes of information that do not require state agency or SOG Location approval (e.g., Form CMS-855I changes, Form CMS-855B changes not involving ambulatory surgical centers or portable x-ray suppliers, minor Form CMS-855A/B certified provider/supplier changes), the contractor shall:

(i) Furnish written, e-mail, or fax confirmation to the provider that the change has been made; and

(ii) Document the provider file (per section 10.6.19 of this chapter) with the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP code change, the contractor need not send confirmation to the provider that it has processed the change.

3. Confirmation of Change in Practice Location Address

In cases where a provider submits a Form CMS-855 or Form CMS-20134 request to change its practice location address, the contractor shall contact the location currently associated with the provider in PECOS or MCS to verify that the provider/supplier is no longer there and did in fact move.

D. Change in Special Payments Address

If the provider/supplier submits a change to its special payments address, the contractor shall verify the change by contacting the individual physician/practitioner (Form CMS-855I changes), an authorized or delegated official (Form CMS-855A, Form CMS-855B, and Form CMS-20134 changes), or the contact person listed in Section 13 (for Form CMS-855A, Form CMS-855B, Form CMS-20134, and Form CMS-855I changes). If the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

When processing a revalidation application, the contractor shall (unless another CMS directive instructs otherwise) follow the instructions in sections 10.4.4(D) and 10.4.4(C)(3)

above, respectively, if the practice location address or special payment address on the application is different from that currently associated with the provider in PECOS or MCS.

E. Provider or Supplier Changing Specialty Type

With the exception of individual physicians, *any* provider and supplier (including *a* non-physician practitioner) *that enrolls via the Form CMS-855A, Form CMS-855B, Form CMS-855I, or Form CMS-20134 and that* wish*es* to change their enrolled provider/supplier type must terminate their current enrollment and submit an initial enrollment application. (Screening and an application fee (if applicable) applies for the new enrollment.)

F. Changes Involving Complete Form CMS-855 or CMS-20134 Applications

A provider must submit a complete Form CMS-855 or CMS-20134 application if it (1) submits any change request and (2) does not have an established enrollment record in PECOS. (For purposes of this requirement, the term "change request" includes EFT changes.) It is immaterial whether: (1) the provider or another party (e.g., local government changes street name) was responsible for triggering the changed data; or (2) the signer of the change request or EFT form already has a signature on file with the contractor.

If the contractor receives a change request from a provider that is not in PECOS, the contractor shall develop for the entire application consistent with the procedures described in this chapter (i.e., the contractor shall treat the transaction as a request for additional information). Consistent with existing policies for requesting additional data, the provider has 30 calendar days from the date of the contractor's request to furnish a complete Form CMS-855 or CMS-20134. During this period, the contractor should "hold" (i.e., not process) the change request until the entire application arrives; no L & T record shall be created in PECOS at this point.

If the provider fails to submit a complete application within the aforementioned 30-day period, the contractor shall follow the instructions in section 10.4.1.4.3 of this chapter.

If the provider submits the application, the contractor shall process it in accordance with the instructions in this chapter and all other applicable CMS directives. This includes:

(i) Processing the complete application consistent with the timeframes for initial applications outlined in this chapter.

(ii) Validate all data elements on the Form CMS-855 or CMS-20134 consistent with the instructions in this chapter pertaining to initial applications. The contractor shall not approve the change request until it has verified all data on the complete Form CMS-855 or CMS-20134.

(iii) Creating an L & T record and enrollment record in PECOS prior to approving the change request. (The receipt date should be the date on which the complete application was received, not the date on which the initial change request was received.) The transaction should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the complete application will presumably incorporate the changed data reported on the original Form CMS-855 or CMS-20134 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction.

G. Incomplete or Unverifiable Changes of Information

(The contractor shall follow the instructions in this section 10.4.4(G) if it cannot process the submitted change request to completion.)

There can be instances where a provider has an enrollment record in PECOS and submits a change request but: (1) fails to timely respond to the contractor's request for additional or clarifying information; or (2) the changed information cannot be validated. The contractor in these situations shall reject the change request in accordance with section 10.4.1.4.3 of this chapter. Moreover, if the changed information is of such materiality that the contractor cannot determine whether the provider still meets all enrollment requirements, the contractor shall refer the matter to its PEOG BFL for guidance. Examples include but are not limited to: (i) change in the provider's lone practice location; (ii) change in ownership; or (iii) change in EFT information.

H. Change of EFT Information

If the provider submits a Form CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A, CMS-855B, and Form CMS-20134 enrollees), or the Section 13 contact person on record (for Form CMS-855A, Form CMS-855B, Form CMS-20134 and Form CMS-855I enrollees) to verify the change. If the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.

I. Special Instructions for Certified Providers, ASCs, and Portable X-ray Suppliers

1. Timeframe for State Review

In situations where state review of the change of information is required (see section 10.6.1.2), the contractor may (via any means) advise the provider that it may take several months for the request to be approved.

2. Post-Recommendation Changes

If an applicant submits a change request after the contractor recommends approval of the provider's initial Form CMS-855 application but before the state or SOG Location (as applicable) notifies the contractor that, respectively, it recommends approval of or approves the initial application, the contractor shall process the newly-submitted data as a separate change of information. The contractor shall not take the changed information/corrected pages and, immediately upon receipt, send them directly to the state/SOG Location for incorporation into the existing application. However, the contractor need not enter the change request into PECOS until it receives the aforementioned state or SOG Location (as applicable) approval/recommendation thereof.

In entering the change request into PECOS, the contractor shall use the date on which it received the change request in its mailroom as the actual receipt date in PECOS; the contractor shall not use the date on which the contractor received the aforementioned state/SOG Location approval/recommendation. The contractor shall explain the situation in the "Comments" section in PECOS and in the provider file.

J. Critical Access Hospital (CAH) Addition of New Provider-Based Locations

Regulations found at 42 CFR § 485.610(e)(2) and in the State Operations Manual (SOM), Pub. 100-07, chapter 2, section 2256H state that the CAH's provider-based location must meet certain distance requirements from the main campus of another hospital or CAH.

The contractor shall contact the appropriate SOG Location while processing the Form CMS-855A to verify that the CAH's new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main campus of another hospital or CAH. The contractor may not make a recommendation for approval without receiving a response from the SOG Location.

If the SOG Location finds that CAH's new provider-based location meets the distance requirements, the contractor shall continue processing the application normally. If the SOG Location determines that the location does not meet the distance requirements, the contractor shall reject the application and issue to the CAH the applicable rejection letter outlined in section 10.7 et seq.

The SOG Location will provide the CAH with three options if the location does not meet the distance requirements:

1. The CAH keeps the new provider-based location, which will cause an involuntary termination in 90 days (as outlined in the Pub. 100-07, chapter 3, section 3012).
2. The CAH terminates the new provider-based location and continue its enrollment as a CAH.
3. The CAH keeps the new provider-based location but converts to a hospital (as outlined in Pub. 100-07, chapter 2, sections 2256G and 2256H).

For each option, the contractor shall keep the CAH's enrollment in an approved status in PECOS. For Option #1 above, the contractor will receive notice from the SOG Location of the termination, which will lead to revocation of the CAH's enrollment. For Option #2, the CAH's enrollment remains approved and the contractor shall expect no further communication from the SOG Location. If the CAH chooses Option #3 to convert to a hospital, the contractor will receive a Form CMS-855A to terminate the CAH's enrollment and a new Form CMS-855A to enroll as a hospital.

10.4.5.3 – Receipt and Processing of Revalidation Applications

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. General Situations

1. Unsolicited Applications

An unsolicited revalidation application is one: (1) received more than 7 months prior to the provider's established due date; or (2) involving a provider identified as TBD (to be determined) on the revalidation look-up tool. The contractor shall return such applications using the applicable sample return letter in section 10.7 et seq. within 20 business days of receipt. If applicable, the contractor shall also submit a request to CMS to have the application fee returned to the provider.

2. 7-Month Period and Signatures

The contractor shall accept and process a revalidation application submitted within 7 months of the provider's due date. The submission date of a revalidation application for providers 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 or delegated official.

3. Branches and Sub-Units

Any certified provider sub-unit or branch that has a separate provider agreement must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the sub-unit/branch has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the sub-unit/branch can disclose the revalidation on the main provider's Form CMS-855A; this is because the sub-unit/branch is a practice location of the main provider and not a separately enrolled entity. Separate fees, too, are not required.

4. Collapse of PTANs

If the provider requests to collapse its PTANs per a revalidation, the contractor shall process said requests if appropriate (based on payment localities, etc.).

5. Voluntary Withdrawal

(This subsection (A)(5) does not apply to certified providers/suppliers. See section 10.6.1.3 of this chapter for instructions concerning certified provider/supplier voluntary terminations.)

If a non-certified supplier wishes to voluntarily withdraw from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail, or fax from the individual supplier or the authorized/delegated official (on letterhead); the contractor shall not require the non-certified supplier to complete a Form CMS-855 or CMS-20134 application. If the contractor makes the request via telephone, the contractor shall document the telephone conversation (in accordance with section 10.6.19 et seq, of this chapter) and take the appropriate action in PECOS.

B. Development Required

1. General Instructions

If a revalidation application requires development (i.e., missing application fee, hardship request, reassignments and/or employment arrangements, documentation, signature, etc.), the contractor shall notify the provider via mail, phone, fax or e-mail. The contractor shall develop for all of the missing information in one development request. The provider has 30 days to respond to the contractor's request and may submit the missing information via mail, fax, or e-mail containing scanned documentation; this includes missing signatures and dates. (Note that the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post-revalidation application approval.)

If the contractor can verify licensure and/or educational requirements (e.g., non-physician practitioner's degree or diploma) online, the contractor shall not require the provider to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider need not submit that documentation again with their revalidation application; the contractor may utilize the existing documentation for verification. Residency information is not required as part of a revalidation. In addition, the contractor need not develop for data that is missing on the provider's revalidation application if the provider disclosed the information (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, though with the exception of the following items:

(i) Adverse legal action data
(ii) LBN
(iii) Tax identification number (TIN)

(iv) NPI-legacy number combinations
(v) Supplier/Practitioner type
(vi) DBA name
(vii) Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

The contractor shall not require providers to include the PTAN(s) in Section 2 or 4 of the revalidation application---provided that the provider included the information needed (NPI, TIN, LBN, DBA, etc.) for the contractor to appropriately make the association. If the PTAN was not submitted but is needed to make the connection, the contractor shall use the shared systems, PECOS, or its provider file(s) as a resource before developing with the provider.

*Notwithstanding any other instruction to the contrary in this chapter, t*he contractor *need no longer* develop for the EFT form *on the sole basis* that the provider*/supplier does not have the most current* version of the Form CMS-588 on file. If provider submits an EFT form with a bank letter or voided check, the contractor 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 need not submit that documentation again during the enrollment process. The contractor 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 the instructions in this chapter, the contractor shall document in the provider file that it found the missing information elsewhere in the enrollment package, with previously submitted applications, or with documentation currently uploaded in PECOS. (This excludes information that the contractor must verify at the current point in time (e.g., a license without a primary source verification method). Additionally, the contractor shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

If a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments and/or employment arrangements, the contractor shall develop with 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 contractor shall revalidate the single reassignment and deactivate the reassignments and/or employment arrangements within the enrollment records that were not revalidated.

If other missing information is not received within 30 days, the contractor shall deactivate the provider within 25 days after the development due date and notify the provider of the deactivation using the applicable sample letter in section 10.7 et seq. of this chapter. After deactivation, the provider must submit an entirely new application in order to reactivate their PTANs. The contractor may use any supporting documentation received (if needed) for subsequent application submissions.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date; or (2) the date on which the deactivation occurred due to non-response or incomplete response to a development request for all provider business structures (e.g., organizations, sole proprietors, sole owners, etc.).

2. Illustrations

Consider the following examples that address the instructions in section 10.4.5.3(B)(1):

SCENARIO #1 - The contractor 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 but only addresses the reassignment for Group A. The contractor develops with 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 remains in progress, the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report the missing reassignment information (even post-revalidation application approval). Here, the contractor processes the revalidation application to completion, and the provider experiences no break in billing.

SCENARIO #2 - The contractor 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 contractor but only addresses the reassignment for Group A. The contractor develops with 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. In this situation, Group A's reassignment is revalidated, and the contractor shall deactivate Group B & C's reassignments and/or employment arrangements effective with the date on which the contractor took deactivation action due to non-response or incomplete response to a development request. The approval letter shall identify the reassignments and/or employment arrangements that were revalidated and those that were terminated with the effective date of the reassignment or termination. The provider must submit a full application (Form CMS-855R) to reactivate the reassignment. The reactivation effective date is based on the receipt date of the CMS-855R.

In Scenario #2, therefore: (i) the provider experiences a break in billing but the contractor only deactivates the non-response reassignments and/or employment arrangements; and (ii) the contractor revalidates the other reassignments and/or employment arrangements.)

C. Revalidation Received after a Pend is Applied

If the contractor receives a revalidation application after applying a pend, it shall remove the pend within 15 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail, fax, or e-mail a decision letter to the provider to notify the latter that the contractor has processed the revalidation application.

D. Revalidation Received After a Deactivation Occurs

1. General Guidance

The contractor shall require a deactivated provider to submit a new, full application to reactivate their enrollment record. The contractor shall process the application as a reactivation. The provider shall maintain their original PTAN; however, the contractor shall reflect a gap in coverage (between the deactivation and the reactivation) on the existing PTAN using A/R codes in MCS and based on the application's receipt date. The provider will not receive reimbursement for dates of service in which they were non-compliant with Medicare requirements (deactivated for non-response to revalidation). The contractor shall reactivate group members (with the group enrollment) who had their reassignment associations terminated when the contractor deactivated the group. The effective dates assigned to the reassigned providers should align with the group's effective date per standard reactivation instructions.

2. Certified Providers and Certified Suppliers

Unless CMS instructs otherwise, the contractor shall allow a certified provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed. (As stated in § 424.540(c), a deactivation does not terminate a certified provider/supplier agreement.) In addition, when processing the revalidation application after a deactivation occurs, the contractor shall not require the deactivated certified provider/supplier to obtain a new state surveyor accreditation as a condition of revalidation.

E. Finalizing the Revalidation Application

Prior to processing the revalidation application to completion, the contractor shall:

(i) Ensure that a site visit (if applicable to the provider in question) occurs.

(ii) Ensure that the provider meets all applicable federal regulatory requirements regarding licensure, certification, and/or educational requirements.

(iii) Revalidate the provider's information based on the data in PECOS.

(iv) Verify the practice locations, although the contractor need not contact each location separately. The contractor shall: (1) verify the location(s) by contacting the contact person listed on the application; and (2) note the validation accordingly in the contractor's verification documentation per the instructions in this chapter.

(v) Ensure that the appropriate L&T record type and finalization status are identified in PECOS.

(vi) Ensure that an enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs but not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, e.g., end-dated). If all PTANs have been addressed (e.g., revalidated, end-dated), the enrollment can be marked as revalidated.

(vii) Ensure that PECOS and the claims systems remain consistent. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation (unless instructed otherwise in another CMS directive).

(viii) When processing is complete, issue an approval letter to the contact person (or the provider if no contact person is listed) via mail, fax, or e-mail. If the provider has reassignments that were terminated due to non-response, the approval letter shall contain the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

F. Revalidation Reporting

The contractor need not submit reports on the 5th and 20th of each month for Cycle 2. However, the contractor shall maintain internally (i) the method of delivery for the provider revalidation notices and (ii) the date it sent the e-mail or letter. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but are not limited to: (i) the revalidation notification's delivery date, delivery method, and delivery address; (ii) deactivation date; (iii) provider response date; (iv) reactivation date; and (v) application finalization date, etc.

10.4.7.2 – Revocation Effective Dates *and Miscellaneous Policies*

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Effective Dates

The contractor shall apply a revocation effective date based upon federal regulations at § 424.535(g). In general, and as discussed below, these dates are either prospective or retroactive.

1. Revocations with Retroactive Effective Dates

The following revocation reasons require a retroactive effective date under § 424.535(g):

(1) Federal exclusion or debarment;
(2) Felony conviction as described in 42 CFR §§ 424.535(a)(3) and 1001.2;
(3) License suspension or revocation; or
(4) Determination that the provider or supplier is no longer operational

A revocation based upon any of these reasons 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 is no longer operational. To illustrate, for a revocation involving a licensure revocation/suspension, the revocation effective date (and the date listed on the revocation letter) shall be the date of the actual license revocation/suspension.

2. Revocations with Prospective Effective Dates

The contractor shall use a prospective effective date (i.e., the date that is 30 days after CMS or the CMS contractor mails notice of its determination to the provider) for revocations not based upon one of the four reasons listed in §§ 424.535(g) and section 10.4.7.2(B) above (e.g., § 424.535(a)(8) -- abuse of billing).

3. Revocations Based Upon More than One Reason

When a revocation involves more than one reason, the contractor shall determine whether any of the grounds require a retroactive effective dates (listed in §§ 424.535(g) and section 10.4.7.2(B) above; if a retroactive date is indeed implicated, the contractor shall apply the appropriate retroactive date.

B. (A)(1) Versus (A)(5)

In cases where a revocation is warranted because the provider/supplier's location is vacant, occupied by another party, closed during office hours, etc., or a state survey failure is involved, the contractor shall use § 424.535(a)(5) (rather than § 424.535(a)(1)) as the revocation reason. (This applies to both certified and non-certified providers/suppliers.) No CAP rights are therefore involved.

10.4.8 – Deactivations

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Bases for Contractor Action

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor shall – without prior approval from its PEOG BFL - deactivate a provider/supplier's entire enrollment record and Medicare billing privileges when:

(i) The provider/supplier fails to respond to a revalidation request.

(ii) The provider/supplier fails to respond timely to a revalidation development request.

(iii) The provider/supplier is enrolled in an approved status with neither an active reassignment nor practice location for 90 days or longer. (The deactivation basis shall be 42 CFR § 424.540(a)(4), which permits deactivation if the provider/supplier is not in compliance with all enrollment requirements. See sections 10.4.8(B) and (D) below for more information on this new deactivation ground.)

(iv) The provider/supplier deactivates an EFT agreement and remains enrolled but does not submit a new EFT agreement within 90 days. (The deactivation basis shall be 42 CFR § 424.540(a)(4).)

(v) The provider/supplier is deceased, and a situation arises where: (1) a particular instruction in this chapter calls for deactivation due to the provider's/supplier's death; and (2) said directive does not require obtaining PEOG approval prior to the deactivation. (See reference to 42 CFR § 424.540(a)(6) below.)

The contractor shall not take deactivation action except as specified and permitted in this chapter or other CMS directives.

B. Regulatory Reasons for Deactivation in § 424.540(a)

1. Grounds

Section 424.540(a) lists eight deactivation grounds:

Section 424.540(a)(1) - The provider/supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12-month period will begin the 1st day of the 1st month without a claim submission through the last day of the 12th month without a submitted claim.

Section 424.540(a)(2) - The provider/supplier does not report a change to the information supplied on the enrollment application within the applicable time period required under Title 42.
(For example, a provider/supplier type falling within the purview of § 424.516(e)(1) and (2) failed to report a change in ownership or control within (i) 30 calendar days of when the change occurred, or (b) 90 calendar days of when the change occurred for all other information on the enrollment application.

If the provider/supplier submits a change of information and (a) it appears the change was not reported within 90 days of the change, (b) the contractor did not previously take administrative action against the provider/supplier, and (c) no revocation action is applicable, the contractor should process the change of information without deactivating the provider/supplier's enrollment.

Section 424.540(a)(3) - The provider/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.

Section 424.540(a)(4) - The provider/supplier is not in compliance with all enrollment requirements. (See section 10.4.8(D) below for more information.)

Section 424.540(a)(5) - The provider's/supplier's practice location is non-operational or otherwise invalid. (See section 10.4.8(D) below for more information.)

Section 424.540(a)(6) - The provider/supplier is deceased.

Section 424.540(a)(7) - The provider/supplier is voluntarily withdrawing from Medicare.

Section 424.540(a)(8) - The provider is the seller in an HHA change of ownership under § 424.550(b)(1).

C. Effective Dates

(See § 424.540(d) for regulations concerning deactivation effective dates.)

The effective dates of deactivation*s under § 424.540(a)(1) through (6)* are as follows:

a. Non-Billing (§ 424.540(a)(1)) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the deactivation is imposed.

b. Section 424.540(a)(2), (3), and (4) (see subsection (B) above) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider/ supplier became non-compliant (e.g., the day after the expiration of the 90-day period in which the provider was required to report a change of information).

c. Section 424.540(a)(5) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider's/supplier's practice location became non-operational or otherwise invalid.

d. Section 424.540(a)(6) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date of death of the provider/supplier.

(See subsections 10.4.8(E) and (F) below for information on § 424.540(a)(7) and (8).)

D. Sections 424.540(a)(4) and (a)(5)
(This section 10.4.8(D) is inapplicable to the situations described in section 10.4.8(A)(iii) and (iv). These two scenarios do not require any referral to PEOG; the contractor can take deactivation action on its own volition.)

The grounds for deactivation under § 424.540(a)(4) and (a)(5) mirror the revocation reasons described in, respectively, § 424.535(a)(1) and (a)(5). When sending a potential § 424.535(a)(1) and (a)(5) revocation case to PEOG for review per section 10.4.7.1(A) of this chapter, PEOG will determine whether a revocation or a deactivation (under § 424.540(a)(4) and (a)(5)) is appropriate. The contractor shall not deactivate a provider or supplier under § 424.540(a)(4) or (a)(5) unless PEOG specifically directs the contractor to do so. Moreover, the contractor need not refer a potential § 424.540(a)(4) and (a)(5) deactivation case to PEOG outside of the situation described in per section 10.4.7.1(A).

E. Section 424.540(a)(7)
See section 10.6.1.3 of this chapter for information regarding certified provider/supplier voluntary terminations and section 10.4.3(B) for information on non-certified supplier voluntary terminations.

F. Section 424.540(a)(8)
See section 10.6.1.3 of this chapter for information regarding seller CHOWs.

G. Miscellaneous

1. The deactivation of Medicare billing privileges does not affect a provider/supplier's participation agreement.

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 PEOG BFL for review and approval. The only exception for PEOG BFL review and approval is deactivations due to failure to comply with a revalidation request.

10.4.8.1 – Deactivation Rebuttals

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

(NOTE: Since provider/supplier voluntary terminations and seller CHOW applications are processed as voluntary terminations under, as applicable, sections 10.4.3(B) and 10.6.1.3 of this chapter, no rebuttal rights are involved. Accordingly, this section 10.4.8.1 applies only to § 424.540(a)(1) through (a)(6).)

A. Background

Pursuant to 42 CFR § 424.546, a provider/supplier whose Medicare billing privileges have been deactivated under 42 CFR § 424.540(a) may file a rebuttal. A rebuttal is an opportunity for the provider/supplier to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per deactivation. Additional rebuttal requests shall be dismissed.

If an application is received for a deactivated provider/supplier while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the application consistent with current processing instructions. If the rebuttal determination is issued and overturns the deactivation prior to an application being approved, the contractor shall return the application received while the rebuttal determination was pending unless: (1) the submitted application is required to reactivate the provider/supplier's enrollment; or (2) if there are new changes being reported. If an application (1) is received while a rebuttal submission is pending, (2) is approved prior to the issuance of a rebuttal determination, and (3) results in the provider's/supplier's enrollment being reactivated without a gap in billing privileges, the contractor shall stop processing the rebuttal submission and issue an applicable moot letter.

B. Notification Letters for Deactivations

If a basis is found to deactivate a provider/supplier's Medicare billing privileges under one of the regulatory authorities in 42 CFR § 424.540, the contractor shall deactivate the provider/supplier unless another CMS direction applies. If a revocation authority is applicable, the contractor shall follow the instructions in sections 10.4.7 and 10.4.8 et seq. of this chapter in lieu of deactivating the enrollment. If no revocation authority applies, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the provider/supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.

C. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

The rebuttal submission:

a. Must be received by the contractor within 15 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax;

b. Must specify the facts or issues with which the provider/supplier disagrees, and the reasons for disagreement;

c. Should include all documentation and information the provider/supplier would like to be considered in reviewing the deactivation;

d. Must be submitted in the form of a letter that is signed and dated by the individual provider, supplier, the authorized or delegated official, or a legal representative (as defined in 42 CFR § 498.10). If the legal representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider/ supplier; this statement is sufficient to constitute notice of said authority. If the legal representative is not an attorney, the provider/supplier must file written notice of the appointment of a representative with the contractor. This notice of appointment must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.

If the rebuttal submission is not appropriately signed or if a statement from the attorney or written notice of representation is not included in the submission, the contractor shall send a development request for a proper signature or the missing statement/written notice (using the applicable model letter) before dismissing the rebuttal submission. The contractor shall allow 15 calendar days from the date of the development request letter for the rebuttal submitter to respond to the development request.

If a rebuttal submission (1) is not appropriately signed and no response is received to the development request (if applicable), (2) is untimely (as described above), (3) does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement, or (4) is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable model rebuttal dismissal letter. The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the 15 calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider/supplier's control that prevented the timely submission of a rebuttal. (These uncontrollable circumstances do not include the provider/supplier's failure to timely update its enrollment information, specifically its various addresses.) If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within 5 calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

If the 15th calendar day from the date on the deactivation notice falls on a weekend or federally-recognized holiday, the rebuttal shall be accepted as timely if the contractor received it by the next business day.

It is the provider/supplier's responsibility to timely update its enrollment record to reflect any changes to the provider/supplier's enrollment information including, but not limited to, its

correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

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

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

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

4. Reason-Specific Instructions

a. § 424.540(a)(1)

For deactivations under § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the 12-month period preceding the date of deactivation, starting with the 1st day of the 1st month 12 months prior to the date of deactivation. If it is confirmed that billing occurred within 12 months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the 12-month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination. Consider the following illustration:

EXAMPLE: Dr. Awesome has been enrolled in Medicare since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2016. Dr. Awesome's enrollment is deactivated effective January 1, 2018. Dr. Awesome timely submits a rebuttal statement regarding the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is confirmed that Dr. Awesome had not submitted claims since January 2016. An unfavorable determination would therefore be appropriate in this scenario, for the deactivation was justified.

b. § 424.540(a)(2)

For deactivations under 42 CFR § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within 90 calendar days of when the change occurred. If information was submitted properly and timely, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request, for the deactivation was justified. In making this determination, the contractor shall consider, at minimum, the following.

- Whether the deactivation was implemented after 90 days of when the change of enrollment information occurred.

- Whether the letter notifying the provider/supplier of the deactivation was sent to the correct address as instructed in section 10.7 et seq. of this chapter.
- Whether the enrollment changes were received in an enrollment application that was processed to completion within 90 days of when the change of enrollment occurred.

Consider the following illustration:

EXAMPLE: Dr. Happy has reassigned his benefits to physician group Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's billing privileges are revoked effective January 1, 2018. Dr. Happy's enrollment is deactivated on April 15, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal to the deactivation. Upon the contractor's review of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 90 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy's practice location that was processed to completion was not received within 90 days of the change of enrollment information. Though an application was received within 90 days of the change of enrollment information, that application was not processed to completion. Thus, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

c. § 424.540(a)(3)

For deactivations under 42 CFR § 424.540(a)(3), the contractor shall review all submitted documentation and internal records to determine whether the provider/ supplier furnished complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. In making this determination, the contractor shall consider, at minimum, the following:

- Whether the deactivation was implemented after 90 days of the revalidation request.
- Whether the letter notifying the provider or supplier of the requirement to revalidate was sent to the correct address as instructed in section 10.7 of this chapter.
- Whether a revalidation application was timely received that was processed to completion.

Consider the following scenario:

EXAMPLE: On January 1, 20*22*, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 20*22*. The contractor receives a revalidation application from Dr. Great on March 1, 20*22*. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 20*22* revalidation application and subsequently deactivates Dr. Great's enrollment on April 16, 20*22*. Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Accordingly, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was justified.

d. § 424.540(a)(4) and (5)

For a deactivation under 42 CFR § 424.540(a)(4) or (a)(5), the contractor shall review all submitted documentation and internal records to determine whether: (1) the provider/supplier was, in fact, compliant with all enrollment requirements at the time of the deactivation (for § 424.540(a)(4) deactivations); or (2) the provider's/supplier's practice location was operational or otherwise valid at the time of the deactivation (for § 424.540(a)(5) deactivations).

If the provider/supplier was indeed compliant at the time of the deactivation, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required. If the rebuttal was not submitted properly and timely, the contractor shall dismiss the rebuttal request.

e. § 424.540(a)(6)

Although rebuttals under *§ 424.540(a)(6)* are uncommon, the provider/supplier may submit one. Upon receipt thereof, the contractor shall review all submitted documentation and internal records to determine whether the deactivation pursuant to the regulatory basis in question was, in fact, proper. If it was not, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required. If the rebuttal was not submitted properly and timely, the contractor shall dismiss the rebuttal request.

D. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contactor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent via hard-copy mail to the return address on the rebuttal submission and by e-mail (if a valid e-mail address is available). The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.

If the contractor issues a rebuttal determination favorable to the provider/supplier, it shall make the necessary modification(s) to the provider/supplier's Medicare billing privileges within 10 business days of the date the favorable determination is issued. This may include the elimination of the deactivation altogether so that there is no gap in billing privileges or a change in the deactivation effective date. If the contactor issues a rebuttal determination unfavorable to the provider/supplier, the provider/ supplier's Medicare billing privileges shall remain deactivated until a reactivation application is received and processed to completion.

If a rebuttal determination overturns the deactivation, the contractor shall return any application(s) received while the rebuttal submission was being reviewed or during the rebuttal submission timeframe that has not been processed to completion, unless the application is needed to reactivate the enrollment or if there are new changes being reported. If the contractor confirms that the application is not needed and that no new changes are being reported, the contractor shall use the following return reason in the Returned Application Model Letter found at 10.7.7.A of this chapter in response to the scenario described above: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed."

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

E. No Further Review

Pursuant to 42 CFR § 424.546(f), a determination made regarding a rebuttal request is not an initial determination and is not subject to further review. Thus, no additional appeal rights shall be included on any rebuttal determination letter.

10.6.1.2 – Changes of Information – Skilled Nursing Facilities (SNF)

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

(Until further notice from CMS, the instructions in this section 10.6.1.2 apply only to SNFs; said instructions will eventually apply to all certified provider and certified supplier types, and the instructions are written with this in mind. In the interim, the contractor shall continue to use the existing change of information instructions--now in section 10.6.22.1 of this chapter--for all non-SNF certified provider/supplier types.

When executing the instructions in this section 10.6.1.2, the contractor can disregard directives that obviously do not apply to SNFs (e.g., references to home health agencies, ambulatory surgical centers.)

All references to the SOG Location (formerly the "RO") in this section 10.6.1.2 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

The instructions in this section 10.6.1.2 address the handling of changes of information involving certified providers and certified suppliers. With the transition of certain functions from the SOG Locations to the contractors and the Provider Enrollment & Oversight Group (PEOG), the processing instructions for these changes of information are slightly different from previous guidance. In particular: (1) the SOG Locations will be much less involved in the process; (2) tie-in and tie-out notices will no longer be issued; (3) the contractor will be responsible for finalizing changes previously requiring SOG Location approval; and (4) recommendations of approval will be made to (and reviewed by) the state agency (hereafter occasionally referenced simply as "state") only and not the SOG Location.

Except as stated otherwise:

(1) Any provider-specific instructions in section 10.2.1 et seq. of this chapter pertaining to changes of information (e.g., relocation of a federally qualified health clinic site) take precedence over those in this section 10.6.1.2.

(2) Any instructions pertaining to ownership changes in section 10.6.1.1 et seq. of this chapter take precedence over those in this section 10.6.1.2.

(3) Any instructions pertaining to voluntary terminations of entire enrollments and/or provider agreements in section 10.6.1.3 of this chapter take precedence over those in this section 10.6.1.2.

(4) Any instructions in this section 10.6.1.2 concerning the voluntary termination of a branch, sub-unit, or other practice location that does not involve the termination of the entire enrollment and/or provider agreement take precedence over those in section 10.6.1.3. For instance, suppose a certified provider's Form CMS-855A enrollment has three practice locations and/or sub-units. The provider is voluntarily terminating one of them. Here, the contractor shall use the instructions in section 10.6.1.2 when processing this transaction. Now assume that a provider is of a type that must individually and separately enroll each location. The provider has three separately enrolled locations with three separate provider agreements. The provider seeks to terminate one of these locations. Since this will involve the termination of an individual/entire enrollment and corresponding provider agreement, the instructions in section 10.6.1.3 apply.

A. Changes of Information Requiring Recommendation to the State

1. Types

The following Form CMS-855 transactions require an approval recommendation to (and review by) the state prior to approval:

- Addition of OPT/outpatient speech pathology extension site
- Addition of hospice satellite
- Addition of HHA branch
- Addition or deletion of a prospective payment system (PPS)-excluded psychiatric unit or rehabilitation unit
- Addition or deletion of swing-bed approval (see Section 2A2 of the Form CMS-855A)
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Change and/or relocation of practice location when a survey of the new site may be required. (If the contractor is uncertain as to whether the state will perform a survey, it may (1) contact the state for guidance or (2) make the referral based on the contractor's experience with these types of changes and with the practices of the state in question. Note that a survey often may be required if the location is shifting outside of the existing geographic area.)
- Addition of PXRS practice location

2. Initial Contractor Review and Recommendation

The contractor shall process the change request consistent with the instructions in this chapter (e.g., verification of data, developing for missing or conflicting data). If the contractor determines that the change/addition should be approved, it shall send the appropriate recommendation letter (see section 10.7 et seq.) to the state with all applicable documentation that the contractor currently sends in such situations. The SOG Location need not be copied on the letter.

Nothing in this section 10.6.1.2(A)(2):

- Prohibits the contractor from returning or rejecting the application if grounds for doing so exist.
- Supersedes any applicable requirement for performing a site visit (including the timing of such visits).

3. State Review and Contractor Receipt of Recommendation

The state will review the recommendation of approval, the application, and any other pertinent information. If the state decides to perform a survey, it will do so and notify the contractor thereof.

a. State Recommends Approval

If the state concludes that the change/addition should be approved, it will make a recommendation to this effect to the contractor, typically via a Form CMS-1539 and/or similar confirming documentation. No later than 5 business days after receipt of the recommendation, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov containing general identifying data about the provider (including LBN, NPI, CCN, specialty, facility name and address), a copy of the Form CMS-1539 (or other similar documentation evidencing the state's approval recommendation, if available), the draft provider approval letter, and a description of the change to be made. If, to the contractor's knowledge, a new CCN is required, the name and address of the new entity requiring the CCN should be furnished along with the effective date. If a termination is involved (e.g., HHA branch), the contractor shall include the old CCN and the termination date in the e-mail.

Once PEOG responds to the contractor, the latter may finalize its processing of the application (e.g., sending copies of the provider notification of approval to the state and, if applicable, accrediting organization; switching the PECOS record from "approval recommended" to "approved").

b. State Does Not Recommend Approval

If the state does not recommend approval, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov for guidance. The e-mail to him/her shall contain (1) the identifying data described in (3)(a) above; (2) a copy of the notification from the state declining to recommend approval; and (3) any other information the contractor deems pertinent. PEOG will review the matter and furnish the contractor additional instructions, which the contractor shall follow.

4. Additional Policies

a. Post-Recommendation Inquiries - Once the contractor has made its recommendation for approval to the state, any inquiry the contractor receives from the provider regarding the status of its change request shall be referred to the state.

b. Pending State Recommendation - So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive the state's recommendation after 120 days, it may contact the state to see if its recommendation is forthcoming. The contractor may contact the state every 30 days thereafter to ascertain the recommendation's status.

c. State Practice - The PECOS record should not be switched to "Approved" until the contractor receives the state's approval recommendation. However, if the contractor knows that the state in question generally does not review this type of transaction, the contractor

need not send the transaction to the state and shall instead follow the instructions in section 10.6.1.2(B) below.

B. Post-Approval State Notification Required

Form CMS-855 changes that do not mandate a recommendation to the state but do require post-approval correspondence with *PEOG and the* state (and, if applicable, the accrediting organization) include:

- Deletions/voluntary terminations of practice locations or hospital subunits. (Note that this scenario is different from cases where the provider is voluntary terminating its enrollment as a whole (per section 10.6.1.3 of this chapter) rather than simply terminating a single location or subunit within its enrollment.)

- LBN, TIN, or "doing business as name" changes that do not involve a CHOW

- Address changes that generally do not require a survey of the new location

- Addition of hospital practice location

- Ownership changes that involve neither a 42 CFR § 489.18 CHOW nor a § 424.550(b) exempt or non-exempt change in HHA majority ownership (e.g., a 15 percent owner of a hospice sells her ownership stake).

The contractor shall:

(1) Inform *PEOG, the* state, and the AO (if appropriate) of the changed information (via any mechanism it chooses, including copying *PEOG/*state/AO on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction. Such notice to the *PEOG/state*/AO shall specify the type of information that is changing. *(Prior PEOG approval of the change is not required, though PEOG will update ASPEN as needed.)*

(*2*) Switch the PECOS record to "Approved."

C. All Other Changes of Information

1. General Principle

For all Form CMS-855 change requests not identified in section 10.6.1.2(A)(1) and (B) above (and except as stated in subsection (C)(2) below), the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made; and (2) switch the PECOS record to "Approved." The contractor need not notify the state, SOG Location, or PEOG of the change.

2. FQHCs

If an FQHC is adding, deleting, or changing a *Section 13* contact person , the contractor shall send an approval letter via e-mail and copy the MedicareProviderEnrollment@cms.hhs.gov mailbox (with "FQHC COI" in the subject line) thereon. (Aside from this exception, all other instructions in subsection (C)(1) apply to this scenario.) *See section 10.2.1.4(D) of this chapter for more information on FQHC changes of information.*

D. Revalidations, Reactivations, and Complete Form CMS-855 Applications

1. When Referral Required - In situations where the provider submits a (1) Form CMS-855 reactivation, (2) Form CMS-855 revalidation, or (3) full Form CMS-855 as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in section 10.6.1.2(A)(1). For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855, the contractor shall make a recommendation to the state and await the state's approval recommendation before switching the record to "Approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state needs to consider is the new hospital unit.

2. No Referral Required - If the application contains new/changed data falling within one of the categories in section 10.6.1.2(B), the contractor can switch the PECOS record to "Approved." It shall also inform the state of the changed information (via any mechanism it chooses, including copying the state on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction.

E. Unsolicited Notifications from State

If the contractor receives notice of a provider's change of information from the state but the provider never submitted the required Form CMS-855 change request to the contractor, the contractor shall: (1) alert the state of the situation; and (2) contact the provider and have it complete and submit the change request. However, if the data in question is not collected on the Form CMS-855, the contractor need not make this request.

F. Clock Stoppages and Processing Alternatives - While awaiting PEOG's reply on any matter in this section 10.6.1.2 in which the contractor is required to refer a matter to PEOG - and beginning on the date following the sending of the e-mail referenced therein - the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's final response. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

In addition, nothing in this section 10.6.1.3 negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.3.

10.6.1.3 – Voluntary Terminations

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

The CMS Provider Enrollment & Oversight Group (PEOG) and Medicare Administrative Contractors have assumed a number of enrollment-related functions previously handled by state agencies (hereafter occasionally referenced as "state") and CMS Survey & Operations Group Locations (SOG Locations) concerning certified provider and certified supplier voluntary terminations. This section 10.6.1.3 instructs the contractor on how to process such transactions. Unless stated otherwise, these instructions take precedence over those in section 10.4.*3* of this chapter.

A. Background

Consistent with the principles of 42 CFR § 489.52(a) (and except as otherwise required), a certified provider/supplier that wishes to terminate its agreement with Medicare must send written notice of its intention to the SOG Location, the state agency, or the contractor within

the timeframes addressed in § 489.52. Under CMS Publication (Pub.) 100-07, chapter 2, section 2005F, the notice is a letter on letterhead with an authorized signature.

Submission of a Form CMS-855 voluntary termination application is not mandatory but is highly preferred. Providers and suppliers are encouraged to continue to submit this form.

Section 10.6.1.3(B) below discusses various scenarios that the contractor may encounter in processing certified provider/supplier voluntary terminations. These should be reviewed and considered in conjunction with the policies in section 10.6.1.3(C) below, particularly those in subsections (C)(2), (C)(3), (C)(6), and (C)(7).

B. Situations and Scenarios

1. Termination Reported to Contractor Via Form CMS-855 or Letter with No Prior Notice from State Agency or SOG Location

If the contractor receives a Form CMS-855 voluntary termination application or a voluntary termination letter (but not both) directly from a certified provider/supplier without having received any termination notification from the state/SOG Location, the following apply:

(i) The contractor shall: (a) process the application/letter consistent with the timeframes for voluntary terminations in section 10.4.*3* of this chapter; and (b) as applicable, follow the instructions in section 10.6.1.3(C) below.

(NOTE: If the application/letter is from a skilled nursing facility (SNF), the contractor shall contact the state agency to determine whether the SNF *complies* with the requirements of 42 CFR §§ 483.15(c)(8) and 483.70(l). These two provisions address the SNF's required notice to the state of an impending closure and patient safety. If the state indicates that the SNF is not compliant, the contractor shall contact its PEOG Business Function Lead (BFL) for guidance; if compliance is confirmed, the contractor can proceed as normal.)

(ii) Prior to finalizing its processing of the Form CMS-855 or letter submission, the contractor shall e-mail a copy of the draft approval letter (see the *applicable* model letter in section 10.7.*5.1*) containing the appropriate termination effective date, reason for termination, and source of the termination notice (i.e., Form CMS-855 or letter) to PEOG at MedicareProviderEnrollment@cms.hhs.gov, with "S&C Voluntary Termination" in the e-mail's subject line.

(iii) PEOG will update the Automated Survey Process Environment (ASPEN) system, notify the contractor thereof, and, if the provider/supplier is deemed, provide the contractor the name and e-mail address of the applicable accreditation organization (AO).

(iv) Within 3 business days of receiving of the aforementioned notice from PEOG, the contractor shall: (1) e-mail a copy of the final signed approval letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed); and (2) deactivate the provider/supplier in the Provider Enrollment, Chain and Ownership System (PECOS) pursuant to the instructions/guidance in section 10.6.1.3(C)(9) below.

2. Termination Reported to Contractor Via Form CMS-855 and Letter with No Prior Notice from State Agency or SOG Location

If the contractor receives a Form CMS-855 voluntary termination application and a voluntary termination letter directly from a certified provider/supplier without having received any termination notification from the state/SOG Location, the following apply:

(i) If the Form CMS-855 and letter arrive either simultaneously or before the contractor begins processing one of them, the contractor has the discretion to determine which submission to process. It need not process both of them; the submission that the contractor does not process may be returned (consistent with the instructions in this chapter) or placed in the provider/supplier file, and the contractor need take no further action thereon.

(ii) If the contractor receives both submissions and it has begun processing one of them, the contractor shall continue processing that document. The contractor can return the other submission (consistent with the instructions in this chapter) or place it in the provider/supplier file; no further action thereon is required.

(iii) Regardless of whether (2)(i) or (ii) applies, the contractor shall process the submission consistent with the instructions in section 10.6.1.3(B)(1) above.

3. Notice of Voluntary Termination Received from State Agency and/or SOG Location without the Contractor Having Received a Form CMS-855 or Letter Directly From the Provider/Supplier

Although many voluntary termination submissions from certified providers/suppliers are via the Form CMS-855, there are occasions where the provider/supplier will only notify the state agency and/or SOG Location. The contractor will typically learn of this when it receives a Form CMS-1539 ("Medicare/Medicaid Certification and Transmittal") and/or other written notification from the state/SOG Location. (The state uses the Form CMS-1539 to communicate findings to the SOG Location with respect to a facility's compliance with health and safety requirements.) In such situations, the following apply:

(i) The contractor may accept from the state/SOG Location written documentation other than the Form CMS-1539. This includes, for example, a Form CMS-2007 or even a voluntary termination letter of the type described in sections 10.6.1.3(B)(1) and (B)(2) above; indeed, the provider/supplier sometimes sends its termination letter directly to the state/SOG Location and the latter simply forwards it to the contractor.

If the contractor has questions concerning said documentation, it shall contact the state/SOG Location for clarification. (This could include situations when it is unclear: (1) whether a termination is involved; (2) which provider/supplier is to be terminated; or (3) if the state forwards to the contractor a termination request that the state received from the provider, whether the state considers it to be a valid termination request.).

(ii) Upon receipt of the Form CMS-1539 (or other/additional state/SOG Location document), the contractor need not develop with the provider/supplier for a Form CMS-855A/B voluntary termination application or a letter. Instead:

(A) The contractor shall abide by the applicable instructions in section 10.6.1.3(C) below (e.g., section (C)(6) regarding effective dates; section (C)(7) concerning cessations of business). If the notice from the state was a voluntary termination letter from the provider/supplier (as described in section 10.6.1.3(B)(3)(i) above), the contractor shall pay particular attention to the instructions in section 10.6.1.3(C)(3) below.

(B) The contractor shall e-mail a copy of the draft approval letter (see section 10.*7.5.1* of this chapter) containing the appropriate termination effective date, reason for termination, and source of the termination notice to MedicareProviderEnrollment@cms.hhs.gov, with "S&C Voluntary Termination" in the subject line.

(C) PEOG will update ASPEN, notify the contractor thereof, and, if the provider/supplier is deemed, provide the contractor the name and e-mail address of the applicable AO.

(D) Within 3 business days of receiving of the aforementioned notice from PEOG, the contractor shall: (1) e-mail a copy of the final signed letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed); and (2) deactivate the provider/supplier in PECOS pursuant to the instructions/guidance in section 10.6.1.3(C)(9)) below.

4. Notification of Termination Received from the State Agency and/or SOG Location and Directly from the Provider/Supplier Via the Form CMS-855 and/or Letter

The contractor shall adhere to the instructions in this section (B)(4) in the following situations:

(i) The contractor receives notification of termination (i.e., via Form CMS-1539 or other documentation) from the state/SOG Location after the provider/supplier has been deactivated in PECOS pursuant to the latter's Form CMS-855/letter voluntary termination submission - Within 10 calendar days of receiving the state/SOG Location notification, the contractor shall inform the state/SOG Location via e-mail that the provider/supplier has already been deactivated in PECOS and terminated in ASPEN. No further action by the contractor is necessary.

(ii) The contractor receives notification of termination from the state/SOG Location while the contractor is processing a Form CMS-855/letter voluntary termination submission but before the provider/supplier has been deactivated in PECOS – The contractor shall: (i) continue processing the application/letter normally and to completion, consistent with the instructions in this section 10.6.1.3; and (ii) e-mail a copy of the final signed letter to the provider/supplier, SOG Location, state agency, and AO (if the provider/supplier is deemed) after the provider/supplier has been deactivated *in PECOS*.

(iii) The contractor receives notification of termination (i.e., via Form CMS-1539 or other documentation) from the state/SOG Location before the contractor received or began processing the provider's/supplier's Form CMS-855/letter voluntary termination submission – The contractor:

(A) Shall follow the instructions in section 10.6.1.3(B)(3) above

(B) Need not contact the provider/supplier about its Form CMS-855/letter submission prior to the completion of all of the steps in section 10.6.1.3(B)(3)(ii) above

(C) Either in the termination approval letter (which the contractor may modify for the purpose) sent to the provider/supplier or via a simultaneous or separate e-mail to the provider/supplier, the contractor shall notify the provider/supplier that its submission to the contractor was not processed due to the provider/supplier's prior notification to the state/SOG Location. (If this communication is sent separately from the approval letter or the e-mail containing the letter, the contractor shall send the separate e-mail no later than 10 calendar days after sending the letter.)

(iv) The contractor receives notification of termination from the state/SOG Location and a separate voluntary termination Form CMS-855/letter from the provider/supplier without having begun the processing of either – The contractor has the discretion to determine which submission to process. It need not process both of them; the submission that the contractor does not process may be returned (consistent with the instructions in this chapter) or placed in the provider/supplier file, and the contractor need take no further action thereon.

C. Additional Certified Provider/Supplier Voluntary Termination Policies

1. Completion of Form CMS-1539 – The state completes the Form CMS-1539. In Part II thereof, the following fields contain: (i) 26-Termination Action "00"; Code for a voluntary termination; and (ii) 28 –Termination Date; this is the effective date of the voluntary termination.

2. Required Contents of Voluntary Termination Letter Received Directly from Provider/Supplier – If the contractor is processing a voluntary termination letter it received directly from the provider/supplier (as opposed to receiving it from the state/SOG Location), the contractor shall ensure that the letter:

   - Is on the provider/supplier's letterhead
   - Contains the provider/supplier's legal business name, NPI, and CMS Certification Number (CCN)
   - States with sufficient clarity (in the contractor's judgment) that the provider/supplier wishes to terminate its Medicare provider/supplier agreement and/or enrollment. (No exact, uniform, standard language from the provider/supplier is necessary; the letter must merely furnish adequate notice of the provider/supplier's intentions).
   - Is signed and dated by an authorized representative of the provider/supplier. This person need not be on file as an authorized or delegated official of the provider/supplier. The contractor shall accept the person's signature if it has no reason to suspect that he/she lacks the authority to act on the provider/supplier's behalf. If it has doubts, however, it may contact its PEOG for guidance.

   (The applicable regulations do not require that the letter contain the termination effective date or the reason for the termination. For purposes of ascertaining the effective date and reason, the contractor shall follow the instructions in section 10.1.3(C)(6).)

   If the letter does not meet all of the above requirements, the contractor shall develop with the provider/supplier for the missing or deficient information. Development shall be consistent with the general developmental instructions in this chapter (e.g., 30 days for provider/supplier to respond) except as follows:

   - The contractor may develop for the missing or clarifying information via any means, even by telephone. No application development letter is required.
   - Except as stated in sections 10.6.1.3(C)(3) and (C)(6) below, all missing or clarifying data must be furnished via a new letter signed by an authorized representative (who need not be the same person who signed the original letter).

   If the provider/supplier fails to respond fully and completely to the aforementioned request within the required timeframe, the contractor shall contact its PEOG BFL for guidance and include a copy of the initial provider/supplier letter in the e-mail to PEOG.

   (See section 10.6.1.3(C)(3) below for instances where the guidance in this section 10.6.1.3(C)(2) may apply to voluntary termination letters submitted to the state/SOG Location rather than to the contractor.)

3. Provider/Supplier's Voluntary Termination Letter Received Directly from the state/SOG Location Without the Contractor Having Received a Termination Notification from the Provider/Supplier – As explained in section 10.6.1.3(B)(3) above, the contractor may receive a provider/supplier's voluntary termination letter directly from the state/SOG Location without having received any termination notification (i.e., letter or Form CMS-855) from the provider/supplier. If the contractor encounters this situation, the contractor shall adhere to the following:

(i) Provider/Supplier Voluntary Termination Letter Received from State/SOG Location Without Other Confirming Documentation - If the letter is unaccompanied by a Form CMS-1539 or other documentation signifying that the state/SOG Location (1) considers the termination letter as valid or (2) otherwise accepts the termination request, the contractor shall contact the state via e-mail for clarification on these issues. If the state indicates that it considers the provider/supplier as having terminated its provider/supplier agreement, the contractor shall process the termination consistent with the instructions in section 10.6.1.3(B)(3); any missing or unclear information (e.g., reason for the termination, effective date, CCN) shall be obtained from the state and/or SOG Location. If the state is merely forwarding the provider/supplier letter to the contractor for processing without making any determination as to whether the termination is valid, the contractor shall process the letter consistent with the instructions in section 10.6.1.3(B)(1) and (C)(2).

(i) Provider/Supplier Voluntary Termination Letter Received from State/SOG Location With Additional Documentation Confirming that the State Considers the Provider/Supplier As Having Terminated Its Agreement - The contractor shall process the termination consistent with the instructions in section 10.6.1.3(B)(3).

4. Tie-Out Notices – SOG Locations no longer issue tie-out notices (Form CMS-2007) for voluntary terminations.

5. Special Payments - Upon receipt of a Form CMS-855 voluntary termination application or a voluntary termination letter directly from the provider/supplier per the instructions in this section 10.6.1.3, the contractor may (but is not required to) ask the provider/supplier to complete or update the "Special Payments" portion of Section 4 of the Form CMS-855 so that future payments can be sent thereto. If the provider/supplier is adding a special payment address, it should be included in the same transaction as the voluntary termination action (i.e., one transaction incorporating both items). If the provider/supplier is changing its existing special payments address, the transaction constitutes a separate change request (i.e., one termination and one change request). The provider/supplier is not required to submit a Form CMS-588 in conjunction with a termination.

6. Termination Effective Dates and Termination Reasons – As noted previously, § 489.52(b) outlines the applicable effective dates for voluntary terminations. The contractor shall adhere to the following instructions regarding these dates as well as certain situations pertaining to termination reasons:

(i) The contractor receives a Form CMS-855 or voluntary termination letter per section 10.6.1.3(B)(1) or (B)(2) (i.e., the contractor receives a termination submission from the provider/supplier before receiving notification from the state/SOG Location):

(A) If the provider/supplier's submission is missing either the effective date of termination or the reason for the termination (or if either data element is not sufficiently clear to the contractor), the contractor shall develop with the provider/supplier for the missing/unclear data. The contractor may develop for the information via any means, even by telephone; no development letter is required. The provider/supplier must furnish the data via e-mail or other written format, but a new letter is not required. If the provider/supplier fails to submit the requested data within 30 days, the contractor shall contact its PEOG BFL for guidance. If the provider/supplier submits the data, the following effective dates apply:

(1) The termination reason is that the provider/supplier has ceased business (which includes non-operational status) – The termination effective date in ASPEN is that on which the provider/supplier stopped providing services to the community. (See section 10.6.1.3(C)(6)(i)(C) below for additional instructions concerning cessations of business.)

(2) The termination reason does not involve a cessation of business or non-operational status (e.g., the provider simply wishes to depart Medicare without closing its business; the provider elects not to renew its state license) – The contractor shall include on the draft approval letter the termination effective date the provider/supplier furnished. However, the contractor shall include in its e-mail to PEOG (see section 10.6.1.3(B)(1)(ii) above) notification as to whether this effective date is less than 6 months from the date on which the contractor first received the provider/supplier's Form CMS-855/letter. If it is less than 6 months, PEOG will determine whether this termination effective date is acceptable.

(B) If the provider/supplier's initial submission contains the termination effective date and reason, and no development on these issues is needed, the contractor shall proceed as instructed per, as applicable, sections 10.6.1.3(B)(1), (B)(2), and (C)(6)(i)(A) above.

(C) In cases where a cessation of business (including non-operational status) is involved, a retroactive termination effective date is permissible if there were no Medicare beneficiaries receiving services from the facility on or after the requested termination date. The contractor shall confirm this via a claims review prior to forwarding the e-mail and approval letter to PEOG per section 10.6.1.3(B)(1)(ii). If claims were submitted, the contractor shall contact the provider/supplier via e-mail to confirm that services were indeed rendered and adjust the termination date with the provider/supplier; if no adjustment is made or contact cannot be made, an overpayment request must be issued.

(ii) <u>The contractor is processing a Form CMS-1539 or other documentation received from the state/SOG Location other than the provider/supplier's voluntary termination letter</u> – The contractor shall use the termination date listed on the Form CMS-1539 or other documentation as the termination effective date, even if a subsequent submission from the provider/supplier (e.g., Form CMS-855) uses a different date. If no termination date is listed on the submission from the state/SOG Location, the contractor shall contact the state agency for guidance.

Except as otherwise stated in this section 10.6.1.3 or unless directed otherwise by PEOG, the contractor: (1) shall use/apply the termination effective date listed on whichever submission it is processing (e.g., the contractor is processing the provider's Form CMS-855 voluntary termination application before receiving any documentation from the state); and (2) need not alter this termination effective date based on a subsequent submission from provider/supplier or the state/SOG Location.

7. <u>State Agency Performs Survey Based on Cessation of Business</u>

(i) Solicitation of Information

*S*ituations may arise where the state (i) performs a survey of a certified provider/supplier based on a compliant or a cessation of business and (ii) finds that the provider/supplier is no longer operational and/or has vacated the practice location. The state will notify the contractor of its findings via the Form CMS-1539 or other documentation. Upon receipt of this documentation, the contractor shall send to the provider/supplier the applicable notice in

section 10.7.2 of this chapter requesting that the provider/supplier: (1) provide evidence to the contractor (with a copy to the state) that it is still operational; (2) submit a request to the contractor (either via letter or a Form CMS-855) to voluntarily terminate its enrollment; or (3) submit a Form CMS-855 change of information application to report a changed practice location address (and any other changed data). The contractor shall copy the state and SOG Location on the notice and give the provider/supplier 10 calendar days from the date the notice is sent to respond to the request.

(ii) Potential Outcomes

(A) The provider/supplier timely furnishes evidence to the contractor and the state that it is still operational at the same location – The contractor need take no additional action on the matter until it receives confirmation from the state concerning the latter's review. (If the contractor receives evidence from the provider/supplier more than 10 days after the request was made, it shall contact the state for guidance.)

While the contractor may forward the provider/supplier's evidence to the state to ensure that the latter received it, the contractor is not required to do so. It is ultimately (1) the provider/supplier's responsibility to copy the state on its submission to the contractor and (2) up to the state to determine whether the evidence of operational status the provider/supplier submitted is sufficient.

Upon receiving notice from the state as to the review's results, the contractor shall follow the applicable instructions in this section 10.6.1.3 if the provider/supplier is to be terminated (e.g., the state sends a Form CMS-1539 to the contractor). If the provider/supplier was indeed found operational, the contractor need take no further action.

(B) The provider/supplier submits a Form CMS-855 voluntary termination and/or a voluntary termination letter in response to the contractor's aforementioned solicitation - The contractor shall process the submission consistent with the instructions in section 10.6.1.3(B)(1) and/or (B)(2), as applicable. Notwithstanding any instruction to the contrary in this section 10.6.1.3, the contractor shall use the termination effective date listed on the Form CMS-1539 or other documentation from the state (rather than the date on the Form CMS-855/letter) as the termination effective date.

(C) The provider/supplier timely submits a Form CMS-855 to change its address – The contractor shall process the change request to completion, notify the provider/supplier thereof via the applicable instructions in this chapter 10, and forward a copy of the change request via e-mail to the state and SOG Location via e-mail. In this e-mail, the contractor shall: (1) notify the state/SOG Location of the new address; (2) reference the Form CMS-1539 (or other documentation) that the state had sent to the contractor; and (3) notify the state if PECOS indicated any addresses other than the "old" or "new" address at which the provider/supplier might be located.

(D) The provider/supplier fails to respond to the contractor's solicitation - The contractor shall process the voluntary termination consistent with the instructions in section 10.6.1.3(B)(3) above.

8. Clock Stoppages – In any circumstance where the contractor is required under section 10.6.1.3 to contact PEOG (including sending a termination to PEOG for approval) or the state/SOG Location for a determination, approval, or guidance of some type, the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG/state/SOG Location's decision, resolution, determination, or final guidance, as applicable. Interim communication between the contractor and PEOG/state/SOG Location

during such "waiting periods" (e.g., PEOG request for additional information from the contractor) does not restart the clock. Optional communications---that is, communications with PEOG/state/SOG Location that are not specifically directed under this section 10.6.1.3---do not stop the processing clock.

9. *PECOS* Deactivation Date

a. Matching Dates - As indicated previously, the termination effective date will be entered into ASPEN. The date of deactivation *in PECOS* (and except if PEOG instructs otherwise) should match the termination effective date *with the exception of certified suppliers paid via MCS, in which case the PECOS deactivation date shall be the day after the termination date.*

b. Already Deactivated – If the provider/supplier is already deactivated in PECOS pursuant to 42 CFR § 424.540(a)(1) through (a)(6) (i.e., the provider/supplier's billing privileges are merely stopped) and the provider/supplier is now voluntarily terminating their enrollment, no change in the deactivation effective date in PECOS is needed (notwithstanding any contrary instruction in this chapter).

c. Seller CHOW – Notwithstanding paragraph (9)(b) above, the deactivation effective date in PECOS---as well as the voluntary termination date---is the date of the sale; for certified suppliers paid via MCS, however, the PECOS deactivation date shall be the day after the termination date.

10.6.9 – Contact Persons

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

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

The provider may have as many contact persons as it wishes.

If the contractor discovers that a particular contact person qualifies as an owning or managing individual, the provider shall list the person in the Individual Ownership and/or Managing Control section of the application

If multiple contact persons are listed, the contractor has the discretion to select the individual to contact unless the provider indicates otherwise via any means. In addition:

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

(ii) All contact persons shall be stored in PECOS and shall not be removed unless the provider requests the removal via letter, e-mail, fax*, or---if the applicable Form CMS-855 contains an option for deleting a contact person---the Form CMS-855. Irrespective of whether the applicable Form CMS-855 contains such a deletion option,* the contractor *may*

accept end-dates of a contact person via telephone, email, fax, or mail from the provider, the authorized or delegated official, or a current contact person on file. The contractor 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 Form CMS-855.

10.6.10 – Medicare Payment

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Electronic Fund Transfers (EFT)

1. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 or Form CMS-20134 before the contractor can effectuate the change.

It is immaterial whether the provider or the bank was responsible for triggering a change to EFT data (e.g., bank routing number).

Under 42 CFR § 424.510(d)(2)(iv) and § 424.510(e):

(i) All providers (including federal, state and local governments) enrolling in Medicare must use EFT in order to receive payments. *However, a revalidating provider/supplier need not submit the most current version of the Form CMS-588 with its application unless: (1) it has no Form CMS-588 on file at all; or (2) it is changing any of its existing Form CMS-588 data.*

(ii) If a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must continue to receive payments via EFT. However, the change in contractors does not require the provider to submit a new Form CMS-588 unless CMS states otherwise.

(iii) For web-based application submissions, the Form CMS-588 shall be submitted via PECOS upload functionality.

B. Assignment of Part B Provider Transaction Access Numbers (PTANs)

The contractor shall only assign the minimum number of PTANs necessary to ensure that proper payments are made. The contractor shall not assign additional PTAN(s) to a supplier merely because the individual or entity requests one - the only exception being for hospitals that request separate billing numbers for their hospital departments in the Identifying Information/Hospitals Only section of the Form CMS-855B. However, a hospital requesting an additional PTAN must associate the new PTAN with a National Provider Identifier *(NPI)* in the Practice Location Information section of the Form CMS-855B.

C. NPI-Legacy Combinations

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

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

10.6.11 – Participation (Par) Agreements and the Acceptance of Assignment – General Information

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

All providers/suppliers must choose to be either Par or Non-Par when initially enrolling and must maintain the same Par status across all lines of business.

Individual physicians and non-physician practitioners who reassign benefits to a clinic/group practice inherit the Par status established by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice *(*separate from the reassignment of benefits agreement*)*, he/she may designate their own Par status. *See* Publication 100-04, chapter 1, section 30 *for guidance on* applying the correct Par status to clinic/group practices, organizations*,* and individuals in private practice.

The contractor shall follow the instructions in CMS Publication 100-04, chapter 1, sections 30 through 30.3.12.3 when handling issues related to par agreements and assignment. Queries related to the interpretation of such instructions shall be referred to the responsible CMS component.

Physicians and Part B organizations should be entered as Par in PECOS based on the submission of a signed *Form* CMS-460 (Medicare Participating Physician or Supplier Agreement) upon initial enrollment or during a change to their Par status during the annual Medicare Open Enrollment period. Non-Physician Practitioners that are considered mandatory participation and individual physicians and non-physician practitioners that reassign all of their benefits to a Par organization should not be entered as Par in PECOS.

10.6.12 – Opting-Out of Medicare

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

Physicians and practitioners are typically required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. They are also not permitted to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished. However, certain types of physicians and practitioners may "opt-out" of Medicare. A physician or practitioner who opts-out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare-covered services. Medicare does not pay anyone for services (except for certain emergency and urgent care services) furnished by an opt-out physician or practitioner. Instead, opt-out physicians and practitioners sign private contracts with beneficiaries. Please refer to CMS Pub. 100-02, Chapter 15, sections 40 - 40.39 for more information regarding the maintenance of opt-out affidavits and the effects of improper billing of claims during an opt-out period.

The instructions in this section 10.6.12 address the contractor's processing of opt-out affidavits. (See Pub. 100-02, chapter 15, section 40.8 for private contract definitions and requirements.)

A. Who May Opt-Out of Medicare

Only the following physicians and practitioners (sometimes collectively referenced as "eligible practitioners" in this section) can "opt-out" of Medicare:

Physicians who are:

- Doctors of medicine or osteopathy,
- Doctors of dental surgery or dental medicine,
- Doctors of podiatry, or
- Doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the state in which such function or action is performed.

Non-physician practitioners who are

- Physician assistants,
- Nurse practitioners,
- Clinical nurse specialists,
- Certified registered nurse anesthetists,
- Certified nurse midwives,
- Clinical psychologists,
- Clinical social workers, or
- Registered dietitians or nutrition professionals who are legally authorized to practice by the state and otherwise meet Medicare requirements.

(Organizations are not permitted to opt-out of Medicare.)

This means that neither the eligible practitioner nor the beneficiary submits the bill to Medicare for services performed. Instead, the beneficiary pays the eligible practitioner out-of-pocket and neither party is reimbursed by Medicare. In fact, a private contract is signed between the eligible practitioner and the beneficiary that states, in essence, that neither can receive payment from Medicare for the services performed. (The contract, though, must be signed before the services are provided so the beneficiary is fully aware of the eligible practitioner's opt-out status.) Moreover, the eligible practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The contractor's provider enrollment unit must process these affidavits.

Eligible practitioners who opt-out of Medicare are not the same as non-participating physicians/suppliers. The latter are enrolled in Medicare and choose on a claim-by-claim basis whether they want to accept assignment unless the service can only be paid on an assignment-related basis as required by law (e.g., for drugs, ambulance services, etc.). Non-participating physicians/suppliers must therefore comply with Medicare's mandatory claim submission, assignment, and limiting charge rules. Opt-out eligible practitioners, on the other hand, are excused from the mandatory claim submission, assignment, and limiting charge rules, though **only** when they maintain compliance with all of the requirements for opting out.

In an emergency care or urgent care situation, an eligible practitioner who has opted-out may treat a Medicare beneficiary with whom he or she does not have a private contract. In those circumstances, the eligible practitioner must complete a Form CMS-855 application.

B. Requirements for an Opt-out Affidavit

1. Affidavit Contents

As stated in Pub. 100-02, chapter 15, section 40.9, the affidavit shall state that, upon signing the affidavit, the eligible practitioner agrees to the following requirements:

- Except for emergency or urgent care services, during the opt-out period the eligible practitioner will provide services to Medicare beneficiaries only through private contracts, but for their provision under a private contract, would have been Medicare-covered services;

- The eligible practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the eligible practitioner permit any entity acting on the eligible practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary;

- During the opt-out period, the eligible practitioner understands that he/she may receive no direct or indirect Medicare payment for services that the eligible practitioner furnishes to Medicare beneficiaries with whom the eligible practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan;

- An eligible practitioner who opts out of Medicare acknowledges that, during the opt-out period, the eligible practitioner's services are not covered under Medicare and that no Medicare payment may be made to any entity for the eligible practitioner's services, directly or on a capitated basis;

- On acknowledgment by the eligible practitioner to the effect that, during the opt- out period, the eligible practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the eligible practitioner has entered into;

- Acknowledge that the eligible practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the eligible practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom the eligible practitioner has not previously privately contracted) without regard to any payment arrangements the eligible practitioner may make;

- With respect to an eligible practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit;

- Acknowledge that the eligible practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services;

- Identify the eligible practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the eligible practitioner during the opt-out period; and

- Be filed with all MACs that have jurisdiction over claims the eligible practitioner would otherwise file with Medicare; the initial two-year opt-out period will begin the date on which the affidavit meeting the requirements of 42 C.F.R. § 405.420 is signed, provided the affidavit is filed within 10 days after the eligible practitioner signs his or her first private contract with a Medicare beneficiary.

(See Pub. 100-02, chapter 15, section 40.9 for more information on the requirements of opt-out affidavits. See also section 10.6.12(B)(5) below for acceptable opt-out formats.)

The contractor shall review initial opt-out affidavits to ensure that they contain the following information about the eligible practitioner in order to create an affidavit record in PECOS:

- Full name (first, middle and last),
- Birthdate,
- Address and telephone number,
- License information and
- NPI (if one has been obtained), and
- SSN (if no NPI has been issued, though note that this cannot be an individual tax identification number (ITIN)).

If, in order to create a PECOS affidavit record, the contractor needs to obtain data that is missing from an affidavit, it may (1) obtain this information from other sources (such as the state license board) or (2) contact the eligible practitioner only **one time** directly. The contractor shall **not** use Internet-based PECOS or the Form CMS-855 to secure the data from the eligible practitioner, for the eligible practitioner **is not** enrolling in Medicare. If the eligible practitioner is requested to submit missing information to permit the processing of the affidavit and fails to do so within 30 days, the contractor shall reject the opt-out affidavit.

2. Opting-Out and Ordering/Certifying/Referring

If an eligible practitioner who wishes to opt-out elects to order/certify/refer Medicare items or services, the contractor shall develop for the following information (if not provided on the affidavit):

- NPI (if one is not contained on the affidavit voluntarily);
- Date of birth, and;
- SSN (if not contained on the affidavit, though it cannot be an ITIN).

If this information is requested but not received, the eligible practitioner's affidavit can still be processed; however, he/she cannot be listed as an ordering/certifying/referring provider.

3. Adverse Actions

The contractor shall review the List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) for all eligible practitioners who submit opt-out affidavits. Excluded eligible practitioners may opt-out of Medicare but cannot order certify/refer.

As noted in 42 CFR § 405.425(i) and (j), individuals who are revoked from Medicare cannot order, certify, or refer Part A or B services or items to Medicare beneficiaries if they opt-out of Medicare after revocation.

4. No Dual Status

a. Form CMS-855O - Eligible practitioners cannot be enrolled via the Form CMS-855O and actively opted-out simultaneously. Prior to processing an initial Form CMS-855O or opt-out affidavit submission, therefore, the contractor shall confirm that an approved Form CMS-855O enrollment or valid opt-out affidavit does not exist in PECOS. If an approved enrollment or affidavit indeed exists, the contractor shall return the pending application.

b. Form CMS-855I – A Form CMS-855I enrollment can simultaneously exist with a valid opt-out affidavit **only** if the Form CMS-855I is to bill for emergency services. If a Form CMS-855I is received **and** an opt-out affidavit is active, the contractor shall contact the eligible practitioner (via any means) to clarify if he/she submitted the application to solely bill for emergency services provided to a beneficiary. If so, the application shall be processed via normal procedures. If not, the application may be returned. (See Pub. 100-02, chapter 15, section 40.28 for more information on emergency and urgent care services.)

An eligible practitioner who has opted out of Medicare need not also enroll via the Form CMS-855O if he/she wishes to order/refer/certify (e.g., providing the necessary information on his/her affidavit per this section 10.6.12).

5. Acceptable Opt-Out Affidavit Formats

The contractor may provide a sample opt-out affidavit form for eligible practitioners to complete. The opt-out affidavit form must provide spaces for the eligible practitioners to furnish their personal information.

Eligible practitioners may also create their own affidavit. If he/she elects to do so, he/she should include information found in section 10.6.12(B)(1) to ensure timely processing of the opt-out affidavit.

The contractor and eligible practitioners may use the information below as an opt-out affidavit form.

I, {Enter Physician/Non-Physician Practitioner Name}, being duly sworn, depose and say:

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt-out period.

- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.

- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 40.28.

- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under Medicare Advantage.

- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.

- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.

- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.

- I have identified myself sufficiently so that the MAC can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.

- I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two- year opt-out period will begin the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Eligible practitioners should also be encouraged to include the following information (to complete an affidavit record in PECOS): NPI; Medicare Identification Number (if issued); SSN (not an ITIN); date of birth; specialty; e-mail address; any request to order/certify/refer.

C. Effective Date of an Opt-Out Period

As noted in Pub. 100-02, chapter 15, section 40.17, eligible practitioners receive effective dates based on their participation status.

1. Eligible Practitioners Who Have Never Enrolled In Medicare

Eligible practitioners need not enroll prior to opting-out of Medicare. If a non-enrolled eligible practitioner submits an opt-out affidavit, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

2. Non-Participating Practitioners

If an eligible practitioner who is a non-participating provider decides to terminate his/her active Medicare billing enrollment and instead opt-out of Medicare, the effective date of the opt-out period begins the date the affidavit is signed by the eligible practitioner.

3. Participating Practitioners

If an eligible practitioner who is a participating provider (one who accepts assignment for all their Medicare claims) decides to terminate his/her active Medicare billing enrollment and opt-out of Medicare, the effective date of the opt-out period begins the first day of the next calendar quarter. Per 42 CFR § 405.410(d), an eligible practitioner may opt-out of Medicare

at the beginning of any calendar quarter, provided that the affidavit described in 42 CFR § 405.420 is submitted to the applicable contractor(s) at least 30 days before the beginning of the selected calendar quarter. (The contractor shall, however, add 5 calendar days to the 30-day period to allow for mailing.) An opt-out affidavit must therefore be submitted at least 30 days before the first day of the calendar quarter in order to receive January 1, April 1, July 1 or October 1 as the effective date. If the opt-out affidavit is submitted within 30 days prior to January 1, April 1, July 1 or October 1, the effective date would be the first day of the next calendar quarter. (For example, an enrolled participating eligible practitioner's opt-out affidavit was submitted on December 10. The eligible practitioner's effective date could not be January 1, for the affidavit was not submitted at least 30 days prior to January 1. The effective date would be April 1.) The eligible practitioner would need to remain enrolled as a participating supplier until the end of the next calendar quarter so that claims can be properly submitted until the opt-out period begins.

4. Opt-Out After Enrollment

(This section 10.6.12(C)(4) applies notwithstanding any instruction to the contrary in this chapter.)

If an enrolled physician or eligible practitioner is now opting-out, the existing PECOS enrollment record shall be end-dated the day after the PECOS affidavit record is effective.

D. Emergency and Urgent Care Services

If an eligible practitioner who has opted-out provides emergency or urgent care services, he/she must apply for enrollment via the Form CMS-855I. Once he/she receives his/her PTAN, he/she must submit the claim(s) for any emergency or urgent care service furnished. The contractor shall contact its PEOG BFL for additional guidance when this type of situation arises. (See Pub. 100-02, chapter 15, section 40.28 for more information on emergency and urgent care services.)

E. Termination of an Opt-Out Affidavit

As noted in Pub. 100-02, chapter 15, section 40.35, an eligible practitioner who has not previously opted-out may terminate his/her opt-out period early. However, he/she must submit written notification thereof (with his/her signature) no later than 90 days after the effective date of the initial 2-year opt-out period. To properly terminate an affidavit, moreover, the eligible practitioner must:

1. Not have previously opted-out of Medicare (the eligible practitioner cannot terminate a renewal of his/her opt-out);
2. Notify all the MACs that the eligible practitioner has filed an affidavit no later than 90 days after the effective date of the affidavit;
3. Notify all beneficiaries (or their legal representation) with whom the eligible practitioner entered into private contracts of the eligible practitioner's decision to terminate his/her opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period and;
4. Refund to each beneficiary with whom the physician or practitioner has privately contracted all payments collected in excess of the Medicare limiting charge or deductibles and coinsurance.

For eligible practitioners who were previously enrolled to bill Medicare for services, the contractor shall reactivate the eligible practitioner's enrollment record in PECOS and

reinstate his/her PTAN as if no opt-out affidavit existed. The eligible practitioner may bill for services provided during the opt-out period.

For eligible practitioners who were not previously enrolled to bill Medicare for services, the contractor shall remove the affidavit record from PECOS; this will help ensure that the eligible practitioner can submit the appropriate application(s) (via PECOS or paper Form CMS-855 for individual and/or reassignment enrollment) in order to establish an enrollment record in PECOS and thus bill for services rendered during the opt-out period.

F. Opt-Out Period Auto-Renewal and Cancellation of the Opt-Out Affidavit

1. General Policies

Eligible practitioners who initially opted-out or renewed an affidavit on or after June 16, 2015 need not submit a renewal of their affidavit. The opt-out will be automatically renewed for another 2-year period. Yet if the eligible practitioner decides to cancel his/her opt-out, he/she must submit a written notice to each contractor to which he or she would file claims (absent the opt-out) not later than 30 days before the end of the current 2 year opt-out period.

If the eligible practitioner decides to enroll in Medicare after his/her opt-out is canceled, he/she must submit a Form CMS-855I application. The effective date of enrollment, however, cannot be before the cancellation date of the opt-out period. (For example, suppose an eligible practitioner submits a cancellation of her opt-out to end the period on March 31, which is two years from the eligible practitioner's opt-out affidavit effective date. Her requested effective date of enrollment cannot be before April 1.)

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, the contractor shall return the cancellation request to the eligible practitioner and provide appeal rights.

2. Auto-Renewal Report and Opt-Out Renewal Alert

The contractor shall issue an Opt-Out Renewal Alert Letter (found in section 10.7.14(E) of this chapter) to any eligible practitioner whose opt-out period is set to auto-renew. For this purpose, CMS will provide a monthly opt-out report to all contractors via the Share Point Ensemble site. The contractor shall access the report monthly through the Share Point Ensemble site. The contractor shall also review the opt-out report for opted-out eligible practitioners that will auto-renew in the next three-and-a-half months. In addition, the contractor shall issue an Auto-Renewal Alert Letter to eligible practitioners at least 90 days prior to the auto-renewal date; the eligible practitioner will thus have at least 60 days prior to the date a cancellation notice must be submitted to cancel the current opt-out.

The Opt-out Auto-Renewal Alert Letter will provide (1) the date on which the current opt-out period will be auto renewed and (2) the date by which the eligible practitioner will need to submit a cancellation request. The letter will also furnish the eligible practitioner appeal rights if he/she fails to submit a cancellation request and the opt-out renews.

The contractor shall (1) complete the Opt-Out Renewal Alert Letter Report to include the date the Alert Letter was issued, (2) post its reports no later than the 15th of the following month to the Share Point Ensemble site, and (3) email its PEOG BFL when the report has been posted.

If an opted-out eligible practitioner submits a Form CMS-855I and/or a CMS-855R without submitting a cancellation request of his or her opt-out, the contractor shall develop for the

cancellation notice. Once the cancellation notice is received, the contractor shall then process the application(s).

If the eligible practitioner submits a cancellation request within 30 days of the end of the current opt-out period or after the opt-out period automatically renews, the contractor shall return the cancellation request to the eligible practitioner and provide appeal rights using the Late Cancellation Request return letter. In addition, if the eligible practitioner submits a cancellation request more than 90 days prior to the auto-renewal date, the contractor shall return the cancellation request to the eligible practitioner using the Cancellation Request Received Too Early return letter.

G. Failure to Properly Cancel or Terminate Opt-Out

Eligible practitioners who fail to properly cancel or terminate their opt-out may appeal the decision to continue (1) the auto-renewal of the opt-out or (2) the eligible practitioner's initial opt-out period.

Opt-out approval letters include appeal rights for eligible practitioners who initially opt-out and fail to properly terminate the opt-out within 90 days of the approval.

10.6.14 – Application Fees

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Background

Pursuant to 42 CFR § 424.514 - and with the exception of physicians, non-physician practitioners, physician group practices, non-physician group practices, and Medicare Diabetes Prevention Program (MDPP) suppliers – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR § 424.515 (regardless of whether the revalidation application was requested by CMS or voluntarily submitted by the provider or supplier), must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

For purposes of this requirement, the term "institutional provider," as defined in 42 CFR § 424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS-855B (not including physician and non-physician practitioner organizations), Form CMS-855S, or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. A physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

For a list of fee requirements broken out by provider/supplier and application type, refer to the Application Fee Matrix.

Except as otherwise noted, nothing in this section 10.6.14 supersedes any other CMS directive to the contractor pertaining to application fees.

(For purposes of this section 10.6.14, the term "provider" will be used in lieu of "institutional provider.")

B. Contractor Activities Upon Receipt

Upon receipt of a paper or Internet-Based PECOS application from a provider that is otherwise required to submit an application fee, the contractor shall first determine whether the application is an initial enrollment, a revalidation, or involves the addition of a practice location. If the application does not fall within any of these categories, the contractor shall process the application as normal. If it does fall within one of these categories, the contractor shall undertake the following:

1. Determine whether the provider has: (1) paid the application fee via Pay.gov (all payments must be made via Pay.gov); and/or (2) included a hardship exception request with the application or certification statement.

2. Outcomes

a. The provider has neither paid the fee nor submitted the hardship exception request-- The contractor shall send a development letter to the provider notifying it that: (i) it has 30 days from the date of the letter to pay the application fee via Pay.gov and any other items that may be missing or needed; and (ii) failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations).

b. The provider has submitted a hardship exception request but has not paid a fee - The contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. If CMS:

- Denies the hardship exception request – CMS will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall determine whether the fee has been submitted via Pay.gov. If the fee is not paid within 30 calendar days, the contractor shall deny the application (initial enrollments and new locations) pursuant to 42 CFR § 424.530(a)(9) or revoke the provider's Medicare billing privileges under 42 CFR § 424.535(a)(6) (revalidations).

  (If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.)

- Approves the hardship exception request - CMS will notify the provider of such in the decision letter (on which the contractor will be copied). The contractor shall continue processing the application as normal.

c. Has submitted a hardship exception request and has paid a fee - The contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. As the fee has been paid, the contractor shall begin processing the application as normal.

C. Fee Amount

1. General Background

*Except as stated in subsection (C)(2), t*he application fee must be in the amount prescribed by CMS for the calendar year (1) in which the application is submitted (for Internet-based PECOS applications) or (2) of the postmark date (for paper applications). The current fee

amount can be found via PECOS at the following link:
https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do

Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Transition to Subsequent Year

There can be situations where the provider submits an application in the previous calendar year without a required fee, the contractor develops for the fee, and the provider submits the fee in the subsequent year. The submitted fee must be that for the subsequent year and not the preceding year.

D. Non-Refundable

Per 42 CFR § 424.514(d)(2)(v), the application fee is non-refundable unless it was submitted with one of the following:

1. A hardship exception request that is subsequently approved;

2. An application that was rejected prior to the contractor's initiation of the screening process, or

3. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR § 424.570.

(For purposes of section 10.6.14(D) only, the term "rejected" includes applications that are returned.)

In addition, the fee should be refunded if: (i) it was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number); or (ii) it was not part of an application submission.

E. Format

The provider must submit the application fee electronically through https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do, either via credit card, debit card, or electronic check.

Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in section 10.4(C) of this chapter (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

F. Practice Locations

DMEPOS suppliers, federally qualified health centers (FQHCs), independent diagnostic testing facilities (IDTFs), and certain other provider and supplier types described in this chapter must individually enroll each site. The enrollment of each site thus requires a separate fee. For **all other providers** (except physicians, non-physician practitioners, and

physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in the Practice Location section of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required; indeed, the fee for providers that are not required to separately enroll each location is based on the application submission, not the number of locations listed on a single application.

G. Other Application Fee Policies

1. PECOS Enrollment Records

The fee is based on the Form CMS-855 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In the Identifying Information/hospital type section of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

2. Group Practices/Clinics

A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is tribally-owned/operated or hospital-owned. Yet if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

3. Change of Ownership via Form CMS-855B or Form CMS-855S

A provider or supplier need not pay an application fee if the application is reporting a change of ownership via the Form CMS-855B or Form CMS-855S. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

4. Reporting a Change in Tax Identification Number

A provider need not pay an application fee if the application is reporting a change in TIN for a Part A, Part B, or DMEPOS provider or supplier.

5. Requesting a Reactivation

A provider need not pay an application fee to reactivate Medicare billing privileges unless the provider/supplier was deactivated for failing to respond to a revalidation request, in which case the resubmitted application constitutes a revalidation (not a reactivation) application, hence requiring a fee.

6. Changing the Physical Location of an Existing Practice Location

A provider need not pay an application fee when changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed in this chapter. Physicians, non-physician practitioners, physician groups, and non-physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per 42 CFR § 424.518. Likewise,

physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

H. Refund Requests

Unless otherwise approved by CMS, the provider must request a refund no later than 150 days from the date it submitted its application. In its request, the provider shall include documentation acceptable to process the refund request. For credit card refunds, the provider shall include its Pay.gov receipt or the Pay.gov tracking ID number.

If a refund is requested and the fee was paid via ACH Debit, the contractor shall collect from the provider a completed "Authorization and Payment Information Form for Electronic Funds Transfer" form (previously furnished to contractors) and submit it to the PEMACReports@cms.hhs.gov mailbox. In the subject line of this e-mail, the contractor shall: (1) identify the provider's legal business name, National Provider Identifier (NPI), and the Pay.gov Tracking ID; and (2) include the completed, previously-mentioned form.

I. Institutional Provider and Fee: Year-to-Year Transition

There may be isolated instances where, at the end of a calendar year, a provider pays the fee amount for that year (Year 1) but the submission date (for Internet-based PECOS applications) or the application postmark date (for paper applications) falls in the beginning of the following year (Year 2). Assuming that Year 2's fee is higher than Year 1's, the provider must pay the Year 2 fee. The contractor shall thus: (1) send an e-mail to its PEOG BFL requesting a full refund of the fee and including any pertinent documentation in support of the request; and (2) send a letter to the provider notifying it that (i) it has 30 days from the date of the letter to pay the correct fee amount (i.e., the Year 2 amount) via Pay.gov and (ii) failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

J. Hardship Exception

1. Background

A provider requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters shall not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider; and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

The application fee generally should not represent a significant burden for an adequately capitalized provider. Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including furnishing

comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a. Considerable bad debt expenses,

b. Significant amount of charity care/financial assistance furnished to patients,

c. Presence of substantive partnerships (whereby clinical and/or financial integration are present) with those who furnish medical care to a disproportionately low-income population,

d. Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e. Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG BFL. CMS has 60 calendar days from the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. CMS will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 10.6.14(K) below.

If the provider fails to submit appropriate documentation to support its request, the contractor need not contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG BFL. It is ultimately the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

K. Appeals of Hardship Determinations

A provider may appeal CMS' denial of its hardship exception request via the procedures outlined below:

1. If the provider is dissatisfied with CMS' decision to deny a hardship exception request, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination (e.g., CMS' denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

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

Notwithstanding the filing of a reconsideration request, the contractor shall still implement the post-hardship exception request instructions in this section 10.6.14(K). A reconsideration request, in other words, does not stay the implementation of section 10.6.14(K)'s instructions.

The CMS has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be: (a) conducted by a CMS staff person who was independent from the initial decision to deny the hardship exception request; and (b) based on CMS' review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, CMS will send a letter to the provider to acknowledge receipt of its request. In its acknowledgment letter, CMS will advise the requesting party that the reconsideration will be conducted and a determination issued within 60 days from the date of the request.

If CMS denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If CMS approves the reconsideration request, it will notify the provider of this via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable:

i. If the application has already been rejected, request that the provider resubmit the application without the fee, or

ii. If Medicare billing privileges have already been revoked, reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

Corrective Action Plans (CAPs) may not be submitted in lieu of or in addition to a request for reconsideration of a hardship exception request denial.

2. If the provider is dissatisfied with the reconsideration determination regarding the application fee, it may request a hearing before an Administrative Law Judge (ALJ). Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

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

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

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request but the application has already been rejected, the contractor – once PEOG informs it of the ALJ's decision - shall notify the provider via letter, e-mail, or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the

date of receipt of the ALJ‘s decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

If the DAB reverses the ALJ’s decision and approves the hardship exception request but the application has already been rejected, the contractor - once PEOG informs it of the DAB’s decision - shall notify the provider via letter, e-mail, or telephone that it may resubmit the application without the fee. If the provider’s Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

To the extent permitted by law, a provider dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such requests shall be filed within 60 days from receipt of the notice of the DAB‘s decision.

10.6.21 – Miscellaneous Enrollment Topics

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

This section 10.6.21 addresses additional provider enrollment policies. Except as otherwise stated, the instructions in this section supersede any other instructions to the contrary in this chapter.

A. Group and Reassignment Reactivation

If a group practice submits a reactivation application after being deactivated for non-response to a revalidation request, the contractor shall reactivate the group’s reassignments when the group’s reactivation application has been approved; Form CMS-855I and/or CMS-855R applications for the reassignments are not required. The effective dates assigned to the reassigned providers shall align with the group’s effective date per existing reactivation instructions.

This section 10.6.21(A) only applies to deactivations based on a non-response to a revalidation request.

B. Specialty Changes

When a Form CMS-855 enrollment application is submitted to report a change to a physician’s or non-physician practitioner’s primary or secondary specialty, the contractor shall not contact the physician, non-physician practitioner, or contact person directly to confirm either the change itself or the individual’s intent to change his/her specialty.

C. Reassignments Related to Revoked or Deactivated Reassignee

The contractor shall end-date in PECOS all reassignment associations and the associated Provider Transaction Access Numbers (PTANs) when revoking or deactivating an individual or organization (reassignee) that is receiving reassigned benefits from an individual practitioner. The end-date shall be the same as the effective date of the revocation or deactivation; this will ensure the appropriate end-date in the Multi-Carrier System (MCS) and prevent improper use of those PTANs. However, the contractor shall not deactivate the individual practitioner’s (reassignor’s) enrollment record even if (1) the reassigned PTAN is the only PTAN on the individual’s enrollment record and/or (2) no other active locations exist (private practice locations or reassignments); the contractor shall allow the practitioner’s/reassignor’s enrollment record to remain in an approved status.

When sending a deactivation, revocation, or voluntary withdrawal letter to the deactivated or revoked non-certified Part B supplier, said letter shall include the following language:

"Please notify all physician assistants and/or group members who reassign benefits to your organization that, in accordance with 42 CFR §424.540(a)(2), their Medicare enrollment status may be deactivated if they fail to update their enrollment record within 90 calendar days.

D. Interstate License Compacts

A new trend in medicine has arisen involving interstate license compacts. While physician compacts streamline the licensure process for physicians who want to practice in multiple states, a separate license from each state in which the physician intends to practice is still issued (if all requirements are met). CMS will continue to rely on the license issued by the state medical board to help confirm compliance with federal requirements.

In a similar vein, certain non-physician practitioner (NPP) compacts allow the NPP to work in a compact member state (other than their home state) without going through the normal process for licensure in the remote state. NPPs working under the authorization of such a compact must meet both the licensure requirements outlined in the primary state of residence and those established by the compact laws adopted by the legislatures of the interstate compact states.

At present, there are interstate compacts involving physicians, physical therapists, occupational therapists, speech language pathologists, and psychologists *(though none for nurse practitioners).* More are possible.

Licenses obtained through an interstate license compact for the above supplier types shall be treated as valid, full licenses for the purposes of meeting federal requirements. The contractor shall *thus* accept Form CMS-855 applications from applicants reporting a license obtained via an interstate license compact. In addition, the contractor shall attempt to verify the interstate license obtained through the compact using the state licensing board website(s) or compact website (if one exists); if neither technique can confirm the interstate license, the contractor shall request documentation from the supplier that validates said data.

10.7 – Model Letters

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

The contractor shall use the following letters when rejecting, returning, approving or denying an application, or when revoking an entity's Medicare billing privileges. Any exceptions to this guidance shall be approved by the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL), unless specified otherwise. The contractor shall document approval received by *its* PEOG BFL for QASP purposes.

A. Issuing Letters *- Model Letter Guidance*

All letters sent by contractors to providers and suppliers shall *contain and/or adhere to* the *formats/requirements addressed in sections 10.7(A) and (B). Note, however, the following:*

(i) For certified provider/supplier types and transactions that have formally "transitioned" as described in section 10.7.5.1, the requirements (e.g., data elements) of the model letters in section 10.7.5.1 take precedence over any contrary instruction in section 10.7. For example, if section 10.7 requires a data element that a specific letter in section 10.7.5.1 pertaining to the same enrollment transaction/situation does not, the section 10.7.5.1 letter requirements supersede the former. Likewise, if section 10.7 requires the removal/addition of language that is/is not in the applicable section 10.7.5.1 letter, the latter controls.

(ii) For certified provider/supplier types and transactions that have not transitioned (and except as otherwise stated in section 10.7 (e.g., subsection (A)(2)(n)), the contractor shall continue to follow the existing instructions in section 10.7 and utilize the letters in section 10.7.5.

1. General Guidance

(a) The CMS logo (2012 version) displayed per previous CMS instructions.

(b) The contractor's logo shall be displayed however the contractor deems appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.

(c) Excluding items in the header or footer, all text shall be written in Times New Roman 12-point font (with the exception of name and address information per USPS requirements).

(d) All dates in letters, except otherwise specified, shall be in the following format: month/dd/YYYY (e.g., January 26, 2012).

(e) Letters shall contain fill-in sections as well as static, or "boilerplate" sections. The fill-in sections are delineated by words in brackets in italic font in the model letters.

(f) The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing *s*tate survey language for certain provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

2. Approval Letters

(a) Part A/B certified provider and supplier paper/web COI and revalidation approval recommended letters shall detail the recommended changes (e.g. practice location changed to 123 Main Street, Baltimore MD 21244).

(b) For COI and revalidation applications that do not require a *t*ie-in or recommendation but require notification to the *SOG Location* as a cc, the contractor shall add the additional fields applicable to the letter (e.g., cc the *state/SOG Location*). The contractor should itemize the changes if it is beneficial to the *SOG Location*.

(c) Part A/B and DME provider and supplier paper/web COI and revalidation letters shall only list the section title (at the sub-section level) from the paper/web *Form* CMS-855 and *Form* CMS-20134 application (e.g., Correspondence Mailing Address, Final Adverse Legal Actions, Remittance Notices/Special Payments Mailing Address, etc.).

(d) If*,* as part of *a* revalidation, the provider*/supplier* only partially revalidates (i.e., a provider has multiple PTANs*, and* one PTAN is revalidated *with* the others end-dated), *the* contractor shall notate the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).

(e) If the provider is submitting a change as part of a voluntary termination application (e.g. special payment address, EFT, authorized official), the contractor shall enter the applicable fields into the Medicare Enrollment information table.

(f) Approval letters may include a generic provider enrollment signature and contact information (e.g. customer service line). *H*owever, all development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts.

(g) Participation status shall only be included in initial and reactivation letters for Part B sole proprietors, Part B sole owners, any Part B organizations and DME suppliers. Change of information approval letters shall only include the participation status if it was changed as part of the application submission.

*(h) The c*ontractor shall add lines to the enrollment information tables on any reactivation letter if the provider/supplier has reactivated following non-response to a revalidation and enrollment information was changed on the application.

(i) The contractor shall enter an effective date *on* all *c*hange of *i*nformation approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality).

*(j) The c*ontractor shall add appeal rights to all *c*hange of *i*nformation and *r*evalidation approval letters if a new PTAN is issued based on the changes (e.g., a new location is added to a new payment locality*;* a new reassignment is created).

(k) If the provider*/supplier* is revalidating multiple reassignments to different groups, *the* contractor shall add additional lines to the grid to identify the separate groups and PTANs.

(l) If the provider*/supplier* revalidates both reassignments and one or more sole proprietorship locations, *the* contractor shall *indicate* on the appropriate letter that *the* approval covers the reassignments and sole proprietorship *locations*.

(m) In the Part B *n*on-*c*ertified supplier letters, *the* contractor shall populate 42 CFR§ 424.205 for MDPP suppliers or § 424.516 for all other providers/suppliers *with* the following paragraph: *"*Submit updates and changes to your enrollment information within the timeframes specified at [42 CFR § 424.516 or 42 CFR§ 424.205]. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.*"*

(n) For all pre-transition and post-transition seller CHOWs (both HHA and non-HHA), the contractor shall use the "M. Approval – Seller CHOW (Part A/B Certified Org") letter in section 10.7.5.1 when voluntarily terminating the seller's enrollment in a 42 CFR § 489.18 CHOW (which includes mergers, acquisitions, and consolidations). The contractor shall use the effective date of the CHOW as the "Effective Date of Enrollment Termination" in the letter.

*(o) The c*ontractor shall remove the following language when issuing the Approval – Voluntary Termination (Part *B Non-Certified* Org or Part B Sole Owner) *letter in section 10.7.6(V)* for a *Part B non-certified supplier*: "Reassignments and any physician assistant employment arrangements are also deactivated", unless other active reassignments/employment arrangements exist on the enrollment.

3. Denial/Revocation Letters

(a) The contractor shall populate the fill-in sections with the appropriate information*,* such as primary regulatory citation, specific denial and revocation reasons, names/addresses, etc.

(b) The fill-in sections shall be indented ½ inch from the normal text of the letter.

(c) All specific or explanatory reasons shall appear in bold type and shall match the federal registry heading. This applies to headings. For example, if the revocation letter contains the following specific explanatory language, the heading should be in bold type and the explanation should be in normal type as shown in the excerpt below:

> **42 CFR § 424.535(a)(8)(i) – Abuse of Billing Privileges**
>
> Data analysis conducted on claims billed by [Dr. Ambassador], for dates of service [Month XX, XXXX], to [Month XX, XXXX], revealed that [Dr. Ambassador] billed for services provided to [XX] Medicare beneficiaries who were deceased on the purported date of service.

(d) There may be more than one primary reason listed.

4. Voluntary Terminations

If a provider/supplier (certified or non-certified) is voluntarily terminating their enrollment, the contractor shall use the applicable voluntary termination letter.

5. No PEOG Approval

The following letter revisions do not require prior PEOG BFL approval. *(Notwithstanding the language in subsection 10.7(A)(i), this includes the letters in section 10.7.5.1 et seq.)*

(a) If the contractor cannot format the enrollment information table as provided in these model letters, the contractor may provide the information in a similar non-table format.

(b) Placing a reference number or numbers between the provider/supplier address and the salutation. *(For Internet-based PECOS applications,* the contractor can include *its* document control number and the Web Tracking ID in this field.)

(c) The contractor shall enter "N/A" or leave blank *a data element in* an enrollment information table if *said* field *is inapplicable* (e.g., doing business as (DBA), effective date for changes).

(d) The contractor shall include the applicable PTAN and NPI for the application submission on the letter. If multiple PTANs or NPIs apply, the contractor should: (1) enter "multiple" in the PTAN and NPI fields*;* (2) copy and add additional PTAN/NPI rows to the enrollment information tables*;* or (3) attach a list of any and all PTAN and NPI combinations that apply in the letter.

(e) For individual revalidation*s in which* multiple PTANs may be revalidating from multiple reassignments or individual associations, the contractor may also list the group*'s* LBN and PTAN *e*ffective *d*ate in connection with the appropriate individual NPI-PTAN combinations. *The c*ontractor *has* flexibility in relaying these fields when multiplicities exist, ensuring they meet the template*'s* reporting requirements.

(f) Appropriate documents attached to specific letters as needed.

(g) Placing language in any letter regarding self-service functions*,* such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

B. **Sending Letters**

The contractor shall note the following:

1. Except as stated otherwise in this chapter (e.g., certain applications from already-transitioned certified provider/supplier types), the contractor shall issue approval letters within 5 business days of approving the application in PECOS.

2. For all applications other than the Form CMS-855S, the contractor shall send development/approval letters, etc., to the contact person if one is listed. *O*therwise, the contractor may send the letter to the provider/supplier at the e-mail, mailing address, or fax provided in the correspondence address or special payments address sections.

*3. The c*ontractor may insert an attention field with the contact's name as part of the mailing address, but the letter should still be addressed to the provider*/supplier*. The National Supplier Clearinghouse shall continue to send letters to the supplier's correspondence address until their automated process can be updated to include the contact person as a recipient of the letters.

4. If the provider*/supplier* submits two *Form* CMS-855Rs concurrently, two separate approval letters shall be issued (one for each group reassignments).

5. For initial, change of information, revalidation, and voluntary termination applications submitted by sole owners, *the* contractor should issue one approval letter. *H*owever, the Medicare enrollment information table shall distinctly list the individual and sole owner information.

6. If, as part of revalidation, a physician assistant is adding and terminating an employment relationship, one letter shall be issued (approving the revalidation). However, the termination and additional employment relationship shall be noted in the approval letter.

7. The contractor shall issue all denial and revocation letters via certified mail.

10.7.5.1 – Part A/B Certified Provider and Supplier Letter Templates – Post-Transition

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

The model letters in this section 10.7.5.1 pertain to certain enrollment transactions involving certified providers and certified suppliers. Except as otherwise stated, the contractor shall begin utilizing these letters (instead of those in section 10.7.5) upon completion of the transition of the applicable CMS Survey & Operations Group (SOG) function to the *contractor* and the CMS Provider Enrollment & Oversight Group (PEOG). In other words, once a provider *specialty, provider agreement, or provider enrollment transaction type* (for example, *voluntary terminations*) has been transitioned, the contractor shall commence using the section 10.7.5.1 letter(s) pertaining to said transaction. CMS will notify contractors once a particular transition has occurred.

For certified provider/supplier transactions (and transaction outcomes) not specifically addressed in this section 10.7.5.1, the contractor shall continue to use the existing model letters in section 10.7 et seq. (even after the aforementioned transition).

In addition:

(i) Most of the documents in this section 10.7.5.1 identify parties that must receive a copy of the letter in question. If an inconsistency exists between said copied parties and those listed elsewhere in this chapter concerning a particular letter, the parties identified in this section 10.7.5.1 take precedence. To illustrate, suppose another section of this chapter requires X, Y,

and Z to be copied on a certain letter while section 10.7.5.1 only requires X to be copied. The contractor in this situation need only copy X.

(ii) The contractor need only copy an accrediting organization (AO) on a particular letter if the provider/supplier has an AO *for the identified provider/supplier specialty*. The contractor can typically ascertain this by checking PECOS (for currently enrolled providers/suppliers) or reviewing the application (for initial enrollments) to see if an AO is disclosed. Also, PEOG will often identify an AO (if one exists) in cases where it must review the transaction before notifying the contractor of its final approval (e.g., CHOWs, certain changes of information, *voluntary termination*).

(i*ii*) See section 10.7.5.1(*P*) below for the applicable e-mail addresses of the SOG Locations. The contractor shall insert the relevant e-mail address into any letter in section 10.7.5.1 that addresses the provider/supplier's right to a reconsideration of a provider agreement determination.

(*i*v) Any data element boxes that the contractor cannot complete because the information is unavailable or inapplicable (e.g., CMS Certification Number (CCN) in certain instances) can be: (1) left blank; (2) denoted with "N/A," "Not applicable," or any similar term; or (3) removed altogether.

(v) The Provider Transaction Access Number (PTAN) box should contain the CCN for all provider/supplier types other than ASCs and PXRSs; the PTAN for the latter two supplier types will be that which the contractor assigns or has assigned.

(vi) The Primary Practice Location Address box shall include the suite number if one was/is listed on the application.

(vii) For the Denial letter in section 15.7.*5.*1(H), the contractor shall indicate (in any manner it chooses) whether the denial pertains to the buyer's or the seller's application if a prospective CHOW was involved.

(viii) In cases where provider/supplier data has changed and the contractor must list "detailed information or application section titles (as applicable)", the contractor has the discretion to list either (i.e., the info or the section titles).

A. Approval – Change of Information (Part A/B Certified Org; No Recommendation to State Was Required)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has approved your Change of Information (COI) application.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	

Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or *application* section titles, as applicable.

Provider/Supplier Agreement-Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& Accrediting Organization (AO), if applicable]

B. Approval - State Agency Approved Change of Information (Part A/B Certified; Recommendation to State Was Required)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the Medicare State Agency. Your change of information application is now approved.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	

Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Changed Information	Include detailed changes or *application* section titles, as applicable

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& AO, if applicable]

C. Approval - State Agency Approved Change of Ownership (Part A/B Certified *Excluding FQHCs*)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]
Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received a response from the State Agency. Your change of ownership application is now approved. The corresponding executed [insert provider/supplier agreement type] is enclosed/attached. Your enrollment and [provider/supplier agreement-specific] information is outlined below:

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date (use effective date of seller's CCN)	
CHOW Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
  - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
  - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.

- Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a reconsideration of the provider/supplier agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to: [Insert: Name and e-mail address of CMS Location Office]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

D. Approval - State Agency Approved Initial (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] received a response from the Medicare State Agency. Your initial enrollment application and [provider/supplier agreement] is approved. Your executed [insert provider/supplier agreement name] is enclosed/attached. The effective date is the date you met all federal requirements.

Medicare Enrollment and Provider/Supplier Specific Participation Agreement Information

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Enrollment Effective Date	

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	
Medicare Year-End Cost Report Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and

include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to: ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

E. Approval Recommended - Initial (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] assessed your initial Medicare enrollment application and your request for participation in the Medicare program as a [insert provider/supplier type] provider/supplier. A recommendation for approval has been forwarded to the [enter name of State Agency], which will review this application for further compliance. A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS.

We will contact you when we have a decision.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Medicare Year-End Cost Report Date	Date that the provider/supplier requested (delete if not applicable)

For questions concerning the application, contact [Insert State] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

F. Approval Recommended – Change of Information, Change of Ownership, Revalidation*, or Reactivation* Containing Changed New/Changed Data that the State Must Review (if applicable) (Part A/B Certified)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] assessed your [change of information, change of ownership, revalidation*, or reactivation*] Medicare enrollment application. A recommendation of approval has been sent to [name of State Agency], which will conduct a review for further compliance.

A survey may be conducted by a State Survey Agency or deemed accrediting organization approved by CMS to ensure compliance.

We will contact you when we have a decision.

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider/Supplier Agreement Information		
CMS Certification Number (CCN)		
Requested Changes (applicable to COI, CHOW, or Revalidation; remove if inapplicable)	Existing	Seller
	New	Buyer
	Effective Date	

For questions concerning the recommended application, contact [Insert State *Agency name*] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

G. Approval Revalidation (Part A/B Certified Org)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your revalidation application *[include if the application was sent to the state:* "and forwarded it to the State Agency. *The State Agency review has also been completed"]. Your Medicare enrollment information is provided below.*

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	*Include detailed changes or application section titles, as applicable.*

Provider/Supplier Agreement Information		
CMS Certification Number (CCN)		
Requested Changes (applicable to COI, CHOW, or Revalidation; remove if inapplicable)	*Existing*	*Seller*
	New	*Buyer*
	Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Enroll, make changes or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

If you are also requesting a provider/supplier agreement reconsideration, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

H. Denial Letter – Post-1539 (Or Other Similar Notice) Received from State Agency for the following application types—Initials, COIs, CHOWs, revalidations, and reactivations

(This letter only applies in cases where:

(1) A recommendation to the state was required per the instructions in this chapter (e.g., the particular revalidation application contained information/changes requiring state review), and (2) The state sends notification to the contractor (e.g., via the 1539 or other notice) that the application should be denied and/or, if applicable, the provider/supplier agreement should be terminated.

As explained in this chapter, certain changes of information and revalidation applications can result in an enrollment revocation and provider agreement termination, though most do not. Accordingly, the contractor shall insert the applicable review result language (e.g., see bracketed options below) in the first paragraph of the letter.)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[The [insert name of State Agency] completed its evaluation of your [initial application] or [change of information] or [change of ownership] or [revalidation] or [reactivation]. [Insert the following language based on the situation involved and the specific result of the state's review:

[INITIAL ENROLLMENT: Your participation in the Medicare Program and your enrollment in the Medicare Program is [denied] for the following reasons]:

[NO REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION INVOLVED: Your application for [insert] is denied for the following reasons]:

[REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION RESULTING FROM THE APPLICATION SUBMISSION. As a result of the state's review, your *provider/supplier agreement for* participation in the Medicare program is terminated and your enrollment in the Medicare program is revoked for the following reason(s]:

[INSERT DENIAL OR TERMINATION REASON GIVEN BY THE STATE AGENCY]

Information about your provider/supplier agreement and your Medicare enrollment are outlined in the text box below.

Medicare Administrative Contractor Name & Contractor Number	
Medicare Enrollment Determination	
Status	**DENIED [OR REVOKED]**
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Provider/Supplier Agreement Determination	
Provider/Supplier Agreement	**DENIED [OR TERMINATED]**
CMS Certification Number (CCN)	

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
  - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
  - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
  - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the

decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

RECONSIDERATIONS REQUEST—MAILING ADDRESSES:

Requests for Reconsideration: Medicare Provider Enrollment: The reconsideration request regarding your Medicare enrollment may be submitted electronically via e-mail to: ProviderEnrollmentAppeals@cms.hhs.gov or addressed as follows:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

[If a failed survey was involved, the contractor shall include the following language here: "Note that any survey deficiencies may only be addressed as part of the provider/supplier agreement reconsideration process."]

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

I. Approval – Voluntary Termination (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are voluntarily terminating your provider/supplier agreement **or** [Insert Contractor name [and Contractor number]] has completed processing your application [or letter] to voluntarily disenroll from the Medicare program. Therefore, your provider agreement has been terminated and your *enrollment in the Medicare program has been voluntarily terminated* effective on the dates shown below.

Medicare Enrollment and Provider Agreement Termination Information

Medicare Enrollment Termination	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of *Enrollment Termination*	

Provider/Supplier Agreement Termination	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

J. Approval – Reactivation (Part A/B Certified Org)

(This letter should be used for reactivation approvals regardless of whether the application was referred to the state agency for review.)

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your reactivation enrollment application.

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	

Provider/Supplier Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and

include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.
- State the issues or findings of fact with which you disagree and the reasons for disagreement.
- Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.
    - If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.
    - If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.
    - Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.
- Include an email address if you want to receive correspondence regarding your appeal via email.

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: *For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:*

[Insert: Name and e-mail address of CMS Location Office]

Your e-mail must include the following in the subject line: "Subject: Medicare Provider/Supplier Agreement Reconsideration Request"

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

(Note: No CC: to State Agency/AO required. Deactivations do not impact certified provider CCN participation status.)

K. Voluntary Termination: Failure to Respond to Request for Information

Month, Day, Year

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference # Application ID

Dear Provider Name (LBN),

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are no longer operational. We have not received a response to the request sent on Month DD, YYYY to update your enrollment information. Therefore, we have disenrolled you from the Medicare program. Your [provider/supplier agreement] has also been terminated.

Medicare Enrollment and Provider Agreement Termination Information

Medicare Enrollment Termination Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type/Specialty	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination	

Provider/Supplier Agreement Termination Information

CMS Certification Number (CCN)	
Effective Date of CCN Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

L. Voluntary Termination Cessation of Business

[Month, Day, Year]

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference Number:

Dear Provider/Supplier Name:

[Insert Contractor name [and Contractor number]] was notified by State Agency Name that on MONTH DD, YYYY, the State Agency attempted to verify if your Type of Provider is operational. The State Agency has reported that your facility was closed, not operational, and/or ceased business at your address of record.

Pursuant to 42 CFR § 489.52(b)(3), CMS considers a cessation of business and providing services to the community to constitute a voluntary withdrawal from the Medicare program.

If you believe that our determination is incorrect and your Type of Provider facility remains operational, you must notify the State Agency and copy this office within 10 days from your receipt of this notice that your facility is still operational and participating in the Medicare program. You must provide the State Agency and this office with information to clarify why your facility was not functional at the address of record at the time the State Agency performed the site survey.

STATE AGENCY NAME
ADDRESS
CITY, STATE, ZIP

We request that you complete and submit a CMS-855 or an application via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) for a change of information to indicate that your facility/practice location remains open and operational or to request a voluntary termination of your enrollment.

If we do not hear from you, your Medicare enrollment and corresponding Provider Agreement will be terminated, pursuant to 42 CFR § 489.52(b)(3).

If you have any questions, please contact our office at:

Sincerely,

[Name]
[Title]
[Company]

M. Approval – Seller CHOW (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the [use "State Agency" or "CMS Survey & Operations Group Location", as appropriate] that the change of ownership involving [insert seller name] is now approved. Therefore, you have been disenrolled from the Medicare program effective on the date shown below.

Medicare Enrollment Termination Information

Medicare Enrollment Termination	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination	

Provider/Supplier Agreement Information	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

N. Federally Qualified Health Centers (FQHCs) – Initial Enrollment Approval Letter

Notwithstanding any other instruction to the contrary in this chapter, the contractor shall use this letter (which was formerly in section 10.7.19 of this chapter) for all FQHC initial enrollment approvals. For all other FQHC transactions (e.g., revalidations), the contractor may use the applicable letters in either 10.7.5 or 10.7.5.1.

[Month, Day, Year]

[FQHC Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [FQHC],

[Insert Contractor] has approved your enrollment as a federally qualified health center (FQHC).

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN)	
PTAN/CCN Effective Date	
Medicare Year-End Cost Report Date	

Provider/Supplier Agreement Information	
CMS Certification Number (CCN)	
Effective Date of CCN	

Included with this letter is a copy of your "Attestation Statement for Federal Qualified Health Center" (Exhibit 177), which CMS has signed.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes to, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

Providers and suppliers may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 C.F.R. Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group
ATTN: Division of Compliance & Appeals

7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

O. Approval – FQHC Change of Ownership

[Month, Day, Year]

[Provider/Supplier Name]
[Address]
[City, State, Zip]
Reference # (Application Tracking Number)

Dear [Provider/Supplier],

Your change of ownership application is now approved. The corresponding executed "Attestation Statement for Federal Qualified Health Center" (Exhibit 177), which CMS has signed, is enclosed/attached. Your enrollment and Exhibit 177 information is outlined below:

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	

Provider Agreement Specific Information	
CMS Certification Number (CCN)	
CCN Effective Date (use effective date of seller's CCN)	
CHOW Effective Date	

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at [phone number].

Enroll, make changes, or view your existing enrollment information by logging into PECOS at https://pecos.cms.hhs.gov.

Submit updates and changes to your enrollment information within the timeframes specified at 42 CFR § 424.516. For more information on the reporting requirements, go to Medicare Learning Network Article SE1617.

Find additional Medicare program information, including billing, fee schedules, and Medicare policies and regulations, at [insert contractor's web address] or https://www.cms.gov.

Right to Submit a Reconsideration Request:

You may request a reconsideration of this determination. This is an independent review conducted by a person not involved in the initial determination. (Optional Coversheet sentence [To facilitate the processing of your reconsideration request, please utilize and include the [attached] coversheet [also found at [[insert web address for coversheet]] with your submission.])

Reconsideration requests must:

- *Be received in writing within 65 calendar days of the date of this letter and mailed or emailed to the address below.*
- *State the issues or findings of fact with which you disagree and the reasons for disagreement.*
- *Be signed by the provider or supplier, an authorized or delegated official that has been reported within your Medicare enrollment record, or an authorized representative.*
    - *If the authorized representative is an attorney, the attorney's statement that he or she has the authority to represent the provider or supplier is sufficient to accept this individual as the representative.*
    - *If the authorized representative is not an attorney, the individual provider, supplier, or authorized or delegated official must file written notice of the appointment of its representative with the submission of the reconsideration request.*
    - *Authorized or delegated officials for groups cannot sign and submit a reconsideration request on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her behalf.*

You may:

- *Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during the administrative appeals process unless an ALJ allows additional information to be submitted.*
- *Include an email address if you want to receive correspondence regarding your appeal via email.*

If a reconsideration is not requested, CMS deems this a waiver of all rights to further administrative review. More information regarding appeal rights can be found at 42 CFR Part 498.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment & Oversight Group

ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

For questions concerning this letter, contact [Insert Contractor] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Attachments: [Include any attachments that the contractor must send to the provider/supplier, the state agency, and/or the AO per the instructions in this chapter 10.]

P. Applicable SOG Location E-mail Boxes

CMS Locations Corporate Email Addresses

CMS LOCATION	BRANCH	EMAIL Address
CMS Boston Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	ACC & LTC	BostonRO-DSC@cms.hhs.gov
CMS Philadelphia Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	ACC & LTC	ROPHIDSC@cms.hhs.gov
CMS New York New Jersey, New York, Puerto Rico, Virgin Islands	ACC & LTC	RONYdsc@cms.hhs.gov
CMS Atlanta Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	ACC & LTC	ROATLHSQ@cms.hhs.gov
CMS Chicago Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	ACC & LTC	ROCHISC@cms.hhs.gov
CMS Kansas City Iowa, Kansas, Missouri, Nebraska	ACC & LTC	ROkcmSCB@cms.hhs.gov

CMS Denver Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	ACC & LTC	DenverMAC@cms.hhs.gov
CMS Dallas Arkansas, Louisiana, New Mexico, Oklahoma, Texas	ACC & LTC	RODALDSC@cms.hhs.gov
CMS San Francisco Arizona, California, Hawaii, Nevada, Pacific Territories	ACC & LTC	ROSFOSO@cms.hhs.gov
CMS Seattle Alaska, Idaho, Oregon, Washington	ACCB LTC	CMS_RO10_CEB@cms.hhs.gov Seattle_LTC@cms.hhs.gov

10.7.12 – Deactivation Model Letter

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

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

[Month] [DD], [YYYY]

[Provider/Supplier Name] (as it appears in PECOS)
[Address]
[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

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

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-*6*]

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

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

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

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

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

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within *15* calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

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

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

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

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

The rebuttal should be sent to the following:
[MAC Rebuttal Receipt Address]
[MAC Rebuttal Receipt Email Address]
[MAC Rebuttal Receipt Fax Number]

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

Sincerely,

[Name] [Title] [Company]

10.7.13 – Rebuttal Model Letters

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the

provider or supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters shall be saved in PDF format.

A. Rebuttal Signature Development Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal submission, received on [Month] [DD], [YYYY].

(If the submission is not properly signed, use the following.) Your submission is not appropriately signed, as required *under 42 C.F.R. § 424.546.* [MAC Name] is requesting that you submit a rebuttal properly signed by the individual provider, supplier, the authorized or delegated official, or a legal representative. Your properly signed submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a statement by the attorney, use the following.) Your submission is missing an attorney statement that he or she has the authority to represent the provider or supplier. [MAC Name] is requesting that you submit a rebuttal that includes an attorney statement that he or she has the authority to represent the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

(If the submission is missing a signed written notice from the provider/supplier authorizing the legal representative to act on his/her/its behalf, use the following.) Your submission is missing a written notice of the appointment of a representative signed by the provider or supplier. [MAC Name] is requesting that you submit written notice of the appointment of a representative that is signed by the provider or supplier within 15 calendar days of the date of this notice. If you do not timely respond to this request, your rebuttal submission may be dismissed.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

B. Rebuttal Further Information Required Development Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD]. [YYYY], [MAC Name] issued a favorable rebuttal determination, reversing the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reactivation of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation]. Please send the required documentation to:

[MAC Rebuttal Receipt Address]

[MAC Rebuttal Receipt Email Address]

[MAC Rebuttal Receipt Fax Number]

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

C. Rebuttal Moot Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal submission, received on [Month] [DD], [YYYY]. On [Month] [DD], [YYYY], [MAC Name] approved an application to reactivate [Name of Provider/Supplier]'s Medicare billing privileges without a gap. Therefore, the issue set forth in the rebuttal submission is no longer actionable. As a result, this issue is moot and a determination will not be made in regards to the rebuttal submission.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

D. Rebuttal Withdrawn Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written withdrawal request in regards to your rebuttal received on [Month] [DD], [YYYY]. [MAC Name] has not yet issued a rebuttal determination. Therefore, [MAC Name] considers your rebuttal to be withdrawn. As a result, a determination will not be issued in response to your rebuttal and your Medicare billing privileges will remain deactivated.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

E. Rebuttal Receipt Acknowledgement Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your rebuttal on behalf of [Provider/Supplier Name]. Please be advised that [MAC Name] has made an interim determination to maintain the deactivation of your Medicare billing privileges. However, [MAC Name] will further review the information and documentation submitted in your rebuttal and will render a final determination regarding the deactivation of your Medicare billing privileges within 30 days of the date of receipt.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

F. Final Rebuttal Decision Email Template

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

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

(To be sent by hard-copy mail and email if email address is provided. Be sure to attach a copy of the final rebuttal determination in PDF format, if sent via email.)

Dear [Name of the person(s) who submitted the rebuttal]:

Please see the attached determination regarding your rebuttal.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

G. Rebuttal Dismissal Model Letters

1. Untimely Rebuttal Dismissal Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination

Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not timely submitted. The deactivation letter was dated [Month] [DD], [YYYY]. A rebuttal must be received within *15* calendar days of the date of the [Month] [DD], [YYYY] deactivation letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. [Provider/Supplier/Legal Representative/Representative] failed to show good cause for its late request. Therefore, [MAC Name] is unable to render a determination in this matter and your Medicare billing privileges will remain deactivated.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

2. Improper Signature Rebuttal Dismissal Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the letter deactivating your Medicare billing privileges dated [Month] [DD], [YYYY].

[MAC Name] is unable to accept your rebuttal as it was not signed by an authorized or delegated official currently on file in your Medicare enrollment, the individual provider or supplier, a legal representative, or did not contain the required statement of representation from an attorney or signed written notice appointing a non-attorney legal representative. The signature requirement is stated in the [Month] [DD], [YYYY] deactivation letter. Please be advised that a properly signed rebuttal must be received within *15* calendar days of the date of the deactivation letter.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

3. No Rebuttal Rights Rebuttal Dismissal Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name].

[MAC Name] is unable to accept your rebuttal submission because the action taken in regards to your Medicare billing privileges does not afford the opportunity for a rebuttal. Under 42 C.F.R. § 424.545(b), only a provider or supplier whose Medicare billing privileges are deactivated may file a rebuttal in accordance with 42 C.F.R. § 405.374.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

4. More than One Submission Rebuttal Dismissal Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], based on the deactivation letter dated [Month] [DD], [YYYY].

[MAC Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10 of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per deactivation. Therefore, [MAC Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY].

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

H. Rebuttal Not Actionable Model Letter (Moot)

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name], concerning the deactivation of [Provider/Supplier Name]'s Medicare billing privileges, effective [Month] [DD], [YYYY].

On [Month] [DD], [YYYY], [MAC Name] reopened the deactivation for [Provider/Supplier Name] and issued a revised initial determination. This revised initial determination rendered the issue set forth in your rebuttal no longer actionable. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

I. Favorable Rebuttal Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

42 C.F.R. § 424.540(a)(1-*6*)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable).

EXHIBITS:

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(**Example:** On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] rejected Home Healthcare Services, LLC's revalidation application prior to 90 calendar days from the date of the revalidation request letter. As a result, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare billing privileges is not justified based on the information available.

This decision is a **FAVORABLE DETERMINATION**. To effectuate this determination, [MAC name] will reinstate [Provider/Supplier Name]'s Medicare billing privileges.

(If additional information is needed from the provider or supplier in order to reactivate the enrollment, the MAC shall state what information is needed from the provider or supplier in this rebuttal determination. MACs shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

J. Unfavorable Rebuttal Model Letter

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

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

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

[Month] [DD], [YYYY]

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

Re: Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXX]
Reference Number: [XXXX] (Internal Tracking)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [MAC Name] based on the deactivation of [Provider/Supplier Name]'s Medicare billing privileges. The deactivation letter was dated [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely. The following determination is based on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

DEACTIVATION REASON:

42 C.F.R. § 424.540(a)(1-*6*)

OTHER APPLICABLE AUTHORITIES:

42 C.F.R. §

Medicare Program Integrity Manual chapter 10.XX (If applicable)

EXHIBITS:

- Exhibit 1: (**Example:** Rebuttal letter to CMS, signed by John Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (**Example:** Letter from MAC to Home Healthcare Services, LLC, dated December 1, 2017, deactivating Home Healthcare Services, LLC's Medicare billing privileges pursuant to 42 C.F.R. § 424.540(a)(3)).

(In this section list each document submitted by the provider or supplier. Each exhibit should include the date, as well as a brief description of the document. You shall also include other documentation not submitted by the provider that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc.)

BACKGROUND:

The documentation related to the matter for [Provider/Supplier Name] has been reviewed and the determination has been made in accordance with the applicable Medicare rules, policies, and program instructions.

[Summarize the facts underlying the case which led up to the submission of the rebuttal.]

REBUTTAL ANALYSIS:

(A rebuttal reviews whether or not an error was made in the implementation of the deactivation of the provider's or supplier's Medicare billing privileges. This section should summarize the statements made by the provider or supplier in its rebuttal. Then conduct analysis of the arguments based on the applicable regulations and sub-regulations, MPIM. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(**Example**: On [Month] [DD], [YYYY], [MAC Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [MAC Name] sent a development request to continue processing Home Healthcare Services, LLC's revalidation application. Home Healthcare Services, LLC did not timely respond to [MAC Name]'s

development request. As a result, [MAC Name] properly rejected Home Healthcare Services, LLC's revalidation application. Therefore, [MAC Name] finds that the deactivation of Home Healthcare Services, LLC's Medicare enrollment under 42 C.F.R. § 424.540(a)(1-*6*) is justified.)

This decision is an **UNFAVORABLE DETERMINATION**. [MAC name] concludes that there was no error made in the deactivation of your Medicare billing privileges. As a result, your Medicare billing privileges will remain deactivated.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]
[Position of Hearing Officer]
[MAC Name]

10.7.15 –Revalidation Notification Letters

(Rev. 11307; Issued: 03- 25-2022; Effective: 03-04-22; Implementation: 04-25-22)

A. Revalidation Letter

REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

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

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

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

What record needs revalidating by [Due date, as Month dd yyyy]
[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

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

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

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

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if*: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data.*
The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

B. Revalidation Letter – CHOW Scenario Only

[month] [day], [year]

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

NPI:
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

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

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

certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

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

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

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if *(1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data.* The current version of the form can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf.

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

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

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

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

Sincerely,
[Your Name]
[Title]

C. Large Group Revalidation Notification Letter

[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]

D. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

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

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

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

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

The CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

How to resume your payments

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

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

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

If you need help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

E. Revalidation Deactivation Letter

STOPPING BILLING PRIVILEGES

[month] [day], [year]

[Provider/Supplier Name]

[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

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

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

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545. The rebuttal must be received by this office in writing within *15* calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

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

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

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

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

The rebuttal should be sent to the following:

[MAC Rebuttal Receipt Address]
[MAC Rebuttal Receipt Email Address]
[MAC Rebuttal Receipt Fax Number]

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

How to recover your billing privileges

Revalidate your Medicare enrollment record, through PECOS.cms.hhs.gov, or [form CMS-855 or Form CMS-20134].

- Online: PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

- Paper: Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

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

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

If you need help
Visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.
Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

F. Revalidation Past-Due Group Member Letter

REVALIDATION | Past-Due Group Member

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

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

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

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

What record needs revalidating

[Name] | **NPI** [NPI] | **PTAN** [PTAN]
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at **go.cms.gov/MedicareRevalidation**.

What your group member needs to do

Revalidate their Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do. or [form CMS-855 or Form CMS-20134].

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

If your group member needs help

Visit **go.cms.gov/MedicareRevalidation**
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

G. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City], [State] [Zip Code]

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/supplier's 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 seven 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 seven 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: https://pecos.cms.hhs.gov/pecos/login.do.

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]
[Company]