CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11949	**Date: April 13, 2023**
	Change Request 13147

SUBJECT: Third Policy Change Request (CR) Regarding Implementation of the Provider Enrollment, Chain and Ownership System (PECOS) 2.0

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update various sections in Chapter 10 of Publication (Pub.) 100-08, Program Integrity Manual, with policies concerning the implementation of PECOS 2.0.

EFFECTIVE DATE: April 21, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 19, 2023

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	10/10.5/Timeliness and Accuracy Standards
R	10/10.6/Additional Topics Pertaining to Medicare Enrollment
R	10/10.6/10.6.1.1.3.1/Step 1 - Initial Review of the CHOW Application
R	10/10.6/10.6.1.1.3.1.1/Special Processing Instructions and Considerations for the Initial Review Process
R	10/10.6/10.6.1.1.4/Additional CHOW Processing Policies
R	10/10.6/10.6.1.3/Voluntary Terminations
R	10/10.6/10.6.2/Establishing Effective Dates
R	10/10.6/10.6.5/National Provider Identifier (NPI)
R	10/10.6/10.6.10/Medicare Payment
R	10/10.6/10.6.13/Ordering/Certifying Suppliers
R	10/10.6/10.6.14/Application Fees
R	10/10.6/10.6.17/Deceased Practitioners
R	10/10.6/10.6.19/Other Medicare Contractor Duties
R	10/10.6/10.6.20/Screening: On-site Inspections and Site Verifications
R	10/10.7/Model Letters
R	10/10.7/10.7.2/Development Letters

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: 11949	Date: April 13, 2023	Change Request: 13147

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EFFECTIVE DATE: April 21, 2023
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I. GENERAL INFORMATION

A. Background: In preparation for the implementation of PECOS 2.0 in 2023, CMS is updating Chapter 10 of Pub. 100-08 via several CRs in 2023. Each CR (none of which is an analysis CR) revises certain sections of Chapter 10 to incorporate PECOS 2.0 enrollment policies therein. This CR, which is the third and final CR in this particular series, updates applicable instructions in Sections 10.5 through 10.7 of Chapter 10 with these policies. Instructions regarding the operational and logistical aspects of the contractors' use of PECOS 2.0 will be issued through guidance outside of the above-referenced series of CRs.

B. Policy: This CR does not involve 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	
13147.1	The contractor shall follow the PECOS 2.0 instructions in Sections 10.5 through 10.7 of Chapter 10 of Pub. 100-08.	X	X	X						NPEAST, NPWEST
13147.2	The contractor shall observe the situations in Sections 10.5 through 10.7 where the instructions of Section 10.3 in Chapter 10 supersede those in Sections 10.5 through 10.7.	X	X	X						NPEAST, NPWEST

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@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 10 – Medicare Enrollment

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(Rev. 11949; Issued: 04-13-23)

10.5 - Timeliness and Accuracy Standards

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

Sections 10.5(A) through 10.5(B)(4) of this chapter address the timeliness and accuracy standards applicable to the processing of Form CMS-855, Form CMS-20134 applications (initial and change of information and revalidation), and opt-out affidavits. Even though the provisions of 42 CFR § 405.818 contain processing timeframes that differ than those in sections 10.5(A) through 10.5(B)(4), the contractor shall adhere to the standards specified in sections 10.5(A) through 10.5(B)(4).

The term "PECOS applications" means web-based applications. For special instructions regarding the processing of applications submitted via PECOS 2.0, see section 10.3 of this chapter. The PECOS instructions in section 10.3 take precedence over those in this section 10.5.

Note that the date of receipt of a PECOS application is the date the contractor received it, not the date on which the application required the contractor's manual intervention per section 10.3.

The processing of an application or opt-out affidavit generally includes, but is not limited to, the following activities:

- *For paper applications - R*eceipt of the application or opt-out affidavit in the contractor's mailroom and forwarding it to the appropriate office for review. *(This is the intake process.)*
- *For PECOS applications - Electronic receipt of the application.*
- *For paper applications – Completing the intake process.*
- Ensuring that the information on the application or opt-out affidavit is verified.
- Requesting and receiving clarifying information.
- Site visit (if necessary).
- Requesting fingerprints (if necessary).
- *For certified providers/suppliers (and as applicable to the transaction and/or provider/supplier type), f*ormal notification to the *state* and/or *CMS Survey & Operations Group (SOG) Location* of the contractor's approval, denial, or recommendation for approval of the application.

(Note: The timeliness metrics discussed in this section are a combination of Part A applications and Part B applications and opt-out affidavits.)

For purposes of *s*ections 10.5(A) and 10.5(B) below:

- The term "site visit" means that the provider or supplier requires an on-site review to determine *whether* the provider or supplier is operational based on the *provider/supplier* type.
- The term "development" means that the contractor needs to contact the provider or supplier for additional information. (A development request (via letter, fax, email, *the*

PCV, or telephone contact for development) to the provider or supplier is considered to be the first development request.)

- The term "fingerprinting" means that 5 percent or greater owners *(including partners who own at least 5 percent)* of a provider or supplier is required to submit fingerprints for an additional level of screening.

A. Standards for Initial and Change of Information Applications and Opt-Out Affidavits

For purposes of sections 10.5(A)(1) through 10.5(A)(4) of this chapter, the term "initial applications" also includes:

- Form CMS-855 or Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the new owner

- "Complete" Form CMS-855 or Form CMS-20134 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in *PECOS*, or (c) as a Form CMS-855 or Form CMS-20134 reactivation

- Opt-out affidavits submitted for an eligible practitioner's first opt-out period

For purposes of sections 10.5(A)(1) through 10.5(A)(4) of this chapter, the term "changes of information" also includes:

- Form CMS-855 and Form CMS-20134 change of ownership, acquisition/merger, and consolidation applications submitted by the old owner

- Form CMS-588 changes submitted without a need for an accompanying complete Form CMS-855 or Form CMS-20134 application

- Form CMS-855R applications submitted independently (i.e., without being part of a Form CMS-855I or Form CMS-855B package)

- Form CMS-855 and Form CMS-20134 voluntary terminations

- Opt-out early termination requests (of initial opt-out affidavits), changes of information and cancellation requests

Initial and change of information application and opt-out timeliness standards shall be reported together. Likewise, initial, change of information, and opt-out affidavit accuracy shall be reported together.

1. Paper Initial and Change of Information Applications and Opt-Out Affidavits - Timeliness

Please refer to *s*ection 10.5 above for definitions of site visits, development, and fingerprinting.

a. Form CMS-855 and Form CMS-20134 Initial and Change of Information Applications and Opt-Out Affidavits That Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of all Form CMS-855 and Form CMS- 20134 initial and change of information applications and opt-out affidavits (initial, changes of information, termination requests and cancellation requests) that require a site visit, development and/or fingerprinting within 65 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits (initial, changes of information, termination requests and cancellation requests) that require a site visit, development and/or fingerprinting within 100 calendar days of receipt.

b. Form CMS-855 and Form CMS-20134 Initial and Change of Information Applications and Opt-Out Affidavits That Do Not Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of all Form CMS-855 and Form CMS- 20134 initial and change of information applications and opt-out affidavits (initials, changes of information, termination and cancellation requests) that do not require a site visit, development and/or fingerprinting within 30 calendar days of receipt.

The contractor shall process 100 percent of all Form CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits (initials, changes of information, termination and cancellation requests) that do not require a site visit, development and/or fingerprinting within 65 calendar days of receipt.

2. Paper Initial and Change of Information Applications and Opt-Out Affidavits – Accuracy

The contractor shall process 98 percent of paper *Form* CMS-855 and Form CMS-20134 initial and change of information applications and opt-out affidavits in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 10.5(A)(1) through 10.5(A)(2) of this chapter) and all other applicable CMS directives.

3. *PECOS* Initial and Change of Information Applications - Timeliness

This process generally includes, but is not limited to, verification of the application in accordance with existing instructions; requesting and receiving clarifying information in accordance with existing instructions; site visit (if required) and/or requesting fingerprints (if necessary). Please refer to Section 10.5 above for definitions of site visits, development, and fingerprinting.

a. *PECOS* Initial and Change of Information Applications That Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of all Form CMS-855 and Form CMS-20134 *PECOS* initial and change of information applications that require a site visit, development and/or fingerprinting within 50 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 *PECOS* initial and change of information applications that require a site visit, development and/or fingerprinting within 85 calendar days of receipt.

b. *PECOS* Initial and Change of Information Applications That Do Not Require a Site Visit, Development and/or Fingerprinting

The contractor shall process 95 percent of Form CMS-855 and Form CMS-20134 *PECOS* initial and change of information applications that do not require a site visit, development and/or fingerprinting within 15 calendar days of receipt and process 100 percent of Form CMS-855 and Form CMS-20134 *PECOS* initial and change of information applications that

do not require a site visit, development and/or fingerprinting within 50 calendar days of receipt.

4. *PECOS* Initial and Change of Information Applications - Accuracy

The contractor shall process 98 percent of Form CMS-855 and Form CMS-20134 *PECOS* initial and change of information applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 10.5(A)(3) above) and all other applicable CMS directives.

B. Standards for Revalidation Applications

For purposes of sections 10.5(B)(1) through 10.5(B)(3)(b) of this chapter, the term "revalidation applications" includes complete Form CMS-855 or Form CMS-20134 revalidation applications submitted by enrolled providers.

1. Paper Revalidation Applications that Require Site Visits, Development and/or Fingerprinting - Timeliness

Please refer to *s*ection 10.5 above for definitions of site visits, development, and fingerprinting.

a. Form CMS-855 and Form CMS-20134 Revalidation Applications That Require a Site Visit, Development and/or Fingerprinting – Timeliness

The contractor shall process 80 percent of paper Form CMS-855 and Form CMS-20134 revalidation applications that require site visits, development and/or fingerprinting within 65 calendar days of receipt and process 100 percent of paper Form CMS-855 and Form CMS-20134 revalidation applications within 100 calendar days of receipt.

b. Paper Revalidation Applications that do not Require Site Visits, Development, and/or Fingerprinting - Timeliness

The contractor shall process 80 percent of paper Form CMS-855 and Form CMS-20134 revalidation applications that do not require site visits, development and/or fingerprinting within 30 calendar days of receipt and process 100 percent of paper Form CMS-855 and Form CMS-20134 revalidation applications within 65 calendar days of receipt.

2. Paper Revalidation Applications - Accuracy

The contractor shall process 98 percent of paper Form CMS-855 and Form CMS-20134 revalidations in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 10.5(B)(1) above) and all other applicable CMS directives.

3. *PECOS* Revalidation Applications - Timeliness

This process generally includes, but is not limited to, verification of the application in accordance with existing instructions; requesting and receiving clarifying information in accordance with existing instructions; site visit (if required) and/or requesting fingerprints (if necessary). Please refer to section 10.5 above for definitions of site visits, development, and fingerprinting.

a. *PECOS* Revalidation Applications That Require a Site Visit, Development and/or Fingerprinting - Timeliness

The contractor shall process 80 percent of all Form CMS-855 and Form CMS- 20134 *PECOS* revalidation applications that require a site visit, development and/or fingerprinting within 50 calendar days of receipt and process 100 percent of all Form CMS-855 and Form CMS-20134 *PECOS* revalidation applications that require a site visit, development and/or fingerprinting within 85 calendar days of receipt.

b. *PECOS* Revalidation Applications That Do Not Require a Site Visit, Development and/or Fingerprinting - Timeliness

The contractor shall process 80 percent of Form CMS-855 and Form CMS-20134 *PECOS* revalidation applications that do not require a site visit, development and/or fingerprinting within 15 calendar days of receipt and process 100 percent of Form CMS-855 and Form CMS-20134 *PECOS* revalidation applications that do not require a site visit, development and/or fingerprinting within 50 calendar days of receipt.

4. *PECOS* Revalidation Applications - Accuracy

The contractor shall process 98 percent of Form CMS-855 and Form CMS-20134 *PECOS* revalidation applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 10.5(B)(1) and 10.5(B)(3)(b) above) and all other applicable CMS directives.

C. General Timeliness Principles

Unless stated otherwise in this chapter or in another CMS directive, the principles discussed below apply to all applications discussed in sections 10.5(A)(1) through 10.5(B)(3) of this chapter (e.g., change of ownership (CHOW) applications submitted by old and new owners, CMS-588 forms).

1. Clock Stoppages

The processing timeliness clock temporarily stops when the situations identified in section 10.5(C)(1) occur:

- Referring an application to the Office of Inspector General (OIG) or the Unified Program Integrity Contractor (UPIC).
- Waiting for a final sales agreement (e.g., CHOW, acquisition/merger).
- Contacting: (i) the *SOG Location*, and/or state *a*gency regarding a provider-based or CHOW determination; (ii) the *SOG Location or state* agency with a question regarding the application of a CMS policy; (iii) *contacting the SOG Location* or state agency.
- Referring a provider or supplier to update their information in the National Plan & Provider Enumeration System.
- Contacting CMS' Provider Enrollment & Oversight Group (PEOG) for the following reasons: questions regarding the application *or* CMS policy*;* an *a*dverse *l*egal *a*ction review; affiliations/overpayments found on the monthly report or PECOS*;* Advanced Provider Screening criminal alerts*;* delayed site visits*; referrals to PEOG (if required under this chapter) for final review of certain certified provider/supplier applications.*

- Referring a provider to the Social Security Administration to resolve a discrepancy involving a social security number or to the Internal Revenue Service to resolve a *t*ax *i*dentification *n*umber or *i*ndividual *t*ax *i*dentification *n*umber issue.

- Contact*ing* another *contractor* for any type of PECOS update (i.e.: locked associates).

- Contact*ing* the PECOS Maintainer for resolutions to system issues (i.e.: RightNow tickets).

- Practice location and *s*pecial *p*ayment address changes *as well as* specialty changes with future dates.

- If fingerprints are required, the timeliness clock stops when the fingerprint request is issued and resumes when the contractor receives the results. *(I*f additional information is developed at the same time as the fingerprint request is issued, no action shall be taken on the developed information until after the fingerprint results are received*.)*

- *Any other clock stoppage expressly permitted in this chapter or by CMS*

Should a dependent application be needed to continue processing (*e.g.,* a *Form* CMS-855R is needed to complete a reassignment when only a *Form* CMS-855I is received), *the processing clock stops* when the development is issued and resumes once the development is received.

*Consistent with section 10.6.19(I), the c*ontractor *shall* document *in PECOS* any delays by identifying when the referral to CMS, the OIG, etc., was made, the reason for the referral, and when a response was received. *The* contractor will *thus* be able to furnish explanatory documentation to CMS should applicable time limits be exceeded. To illustrate, assume that a contractor received an initial Form CMS-855I application on March 1. On March 30, the contractor sent a question to CMS and received a re*sponse* on April 7. The processing time clock stops from March 31 to April 7. The contractor should document *PECOS* to explain that it forwarded the question to CMS, the dates involved, and the reason for the referral.

2. Calendar Days

Unless otherwise stated in this chapter, all days in the processing time clock are "calendar" days, not "business days." If the final day of a metric falls on a weekend or holiday, this *remains* the day by which the application must be processed. If the contractor *cannot* finish processing the application until the next business day, it should document *in PECOS* that the final day of the metric fell on a Saturday/Sunday/holiday and furnish any additional explanation as needed.

3. Date-Stamping *– Paper Applications Only*

As a general rule, all incoming correspondence must be date-stamped on the day it was received in the contractor's mailroom. This includes, but is not limited to:

- Any Form CMS-855 or Form CMS-20134 application, including initials, changes, CHOWs, etc. (The first page of the application must be date-stamped.)

- Letters from providers. (The first page of the letter must be date-stamped.)

- Supporting documentation, such as licenses, certifications, articles of incorporation, and billing agreements. (The first page of the document or the envelope must be date-stamped.)

- Data that the provider furnishes (via mail or fax) per the contractor's request for additional information. (All submitted pages must be date-stamped. This is because *some* contractors interleaf the new/changed pages within the original application. Thus, it is necessary to determine the sequence in which the application and the additional pages were received.)

*(*Note: *PECOS* applications are considered "date stamped" on the date the application was received.)

The timeliness clock begins on the date on which the application/envelope is date-stamped in the contractor's mailroom, not the date on which the application is date-stamped or received by the provider enrollment unit. As such, the date-stamping activities described in the above bullets must be performed in the contractor's mailroom. In cases where the mailroom staff fails to date-stamp a particular document, the provider enrollment unit may date-stamp the page in question. However, there shall not be long lapses between the time it was received in the mailroom and the time the provider enrollment unit date-stamped the pages.

In addition, and unless stated otherwise in this chapter or in another CMS directive, all incoming enrollment applications (including change requests) must be submitted via mail (unless circumstances require submission via fax or email).

4. When the Processing Cycle Ends

For (1) Form CMS-855A applications, and (2) Form CMS-855B applications submitted by ambulatory surgical centers (ASCs) or portable x-ray suppliers, the processing cycle ends on the date that the contractor enters a final status in PECOS *(e.g., denied, returned, rejected, approval recommended)* rather than the date *on which* the contractor sends formal notification *of approval recommended, etc.,* to the *state or SOG Location.* (*Note* that accompanying applications *(e.g., Form* CMS-855R applications submitted with a *Form* CMS-855B for an ASC) would also end their processing cycle).

In situations involving a change request that does not require a recommendation (i.e., it need not be forwarded to and approved by the *s*tate), the cycle ends on the date that the contractor enters a final status (approved, denied, rejected, returned, etc.) in PECOS.

For (1) Form CMS-855I applications, (2) Form CMS-855R applications, (3) Form CMS-855B applications from suppliers other than ASCs and portable x-ray suppliers, (4) Form CMS-20134 and (5) Form CMS-855S applications the processing cycle ends on the date that the contractor enters a final status (approved, denied, rejected, returned, etc.) in PECOS.

5. PECOS *Applications*

See section 10.3 of this chapter for additional information on the processing of PECOS applications.

10.6 -Additional Topics Pertaining to Medicare Enrollment

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

In reviewing the instructions in this section 10.6 et seq., the contractor shall be mindful of the PECOS 2.0 guidance in section 10.3 of this chapter. Note that the latter instructions take precedence over the former with respect to PECOS matters.

10.6.1.1.3.1 – Step 1 - Initial Review of the CHOW Application

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Process

Upon receipt of a Form CMS-855 CHOW application, the contractor shall undertake the following (in whichever order the contractor prefers):

(i) *Ensure that all* data validations otherwise required per this chapter *have been performed.*

(ii) Ensure that the submitted application(s) is complete consistent with the instructions in this chapter.

(iii) Ensure that the provider has submitted all documentation otherwise required per this chapter. For CHOW purposes, this also includes the following:

(a) 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 below for more information on such documents.)

(b) Form CMS-1561 (Health Insurance Benefit Agreement). (In lieu of the Form CMS-1561, rural health clinics (RHCs) must submit the Form CMS-1561A and ambulatory surgical centers (ASCs) must submit the Form CMS-370.) (See https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List for more information.) These forms are generally known as "provider agreements" and "supplier agreements," as applicable.

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

(d) Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf for more information.)

(e) Applicable CMS Form that requests certification in Medicare. (These include, for example, CMS-377 for ASCs, CMS-3427 for end-stage renal disease (ESRD) facilities, etc.) (See https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List for more information.)

(f) Form CMS-1539 - Medicare/Medicaid Certification and Transmittal (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS011722).

(g) Form CMS-2567 – Statement of Deficiencies and Plan of Correction (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS008860).

(h) For skilled nursing facilities (SNFs), a signed patient transfer agreement. (See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Facility-Transfer-Agreement-Example.pdf for an example.)

(The provider must complete, sign, date, and include the applicable CMS forms described in this subsection (A)(iii); the provider need not, of course, complete those sections of the forms that are reserved for CMS. For organizational providers, an authorized official (as defined in § 424.502) must sign the forms; for sole proprietorships, the sole proprietor must sign.)

Notwithstanding the foregoing, if any document in subsection (A)(iii)(b), (d), (e), (f), (g), or (h) above is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

Note that if the application is rejected and this results in the expiration of the applicable time period for reporting the change (e.g., 30 days), the contractor shall e-mail its PEOG BFL notifying him/her of the rejection. PEOG will determine whether the provider's/supplier's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b)(2) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

(iv) Ascertaining whether a formal § 489.18 CHOW has occurred – This involves performing all necessary background research, which can include:

- Reviewing the sales or lease agreement
- Reviewing the ownership information in Sections 2, 5, and 6 of the Form CMS-855A (or Sections 5 and 6 of the Form CMS-855B)
- Reviewing whether the provider checked "Yes" or "No" to the question in Section 2 of the Form CMS-855A concerning the acceptance of assignment of the provider agreement.
- Contacting the provider(s) to request clarification of the sales agreement, etc. (Unless otherwise stated in this chapter, the provider must furnish any such clarification in writing; e-mail *(including the PCV)* is acceptable.)

(v) As applicable, take into account the supplemental instructions in sections 10.6.1.1.3.1(B), 10.6.1.1.3.1.1 and 10.6.1.1.4 of this chapter.

B. Additional Instructions

1. TIN Change - While a CHOW is typically accompanied by a TIN change, this is not always the case. On occasion, the TIN remains the same; conversely, sometimes the provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW may or may not have occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is the central issue. Hence, the contractor shall review the sales/lease agreement closely, for this will help indicate whether a CHOW has occurred. Again, CMS stresses that the terms and conditions of the sales agreement are the primary indicator of the existence or non-existence of a CHOW.

2. Request for Information and/or Clarification – If, after its initial review under subsection (A), the contractor remains uncertain as to whether a CHOW has taken place, the contractor: (i) reserves the right to request any clarifying information from the provider (e.g., additional documentation concerning the sale); and/or (ii) may contact its PEOG BFL or the SOG Location for assistance. (This may include situations where, for instance, (i) the provider believes that the transaction is merely a stock transfer but the contractor disagrees, and (ii) the contractor is uncertain whether the provider is accepting assignment.)

3. Acceptance of Assignment – Regardless of the provider's response to the Form CMS-855 question concerning whether the provider accepts assignment, the contractor shall review the sales/transfer agreement and any other documentation to confirm whether the provider's response is consistent with the agreement. (For example, if the provider responds "no" to the question, the contractor shall review the sales agreement to ensure consistency.) If an inconsistency is discovered, the contractor shall contact the provider for clarification.

4. Situations Requiring Referral to PEOG – The contractor shall refer the case and all supporting documentation (e.g., sales agreement) to its PEOG BFL in either of the following situations:

- The provider reports a CHOW based strictly on a relinquishment by the owner of all authority and responsibility for the provider organization without a § 489.18-level change of ownership. (For instance, the sales agreement indicates that the provider is selling only 10% of its ownership stake but the provider claims the transaction is a CHOW because it is relinquishing all control of the provider to the party to which its 10% ownership share is being sold.)
- It appears the owner of a provider is entering into a franchise agreement with a corporate chain (and thus uses the chain's name).

10.6.1.1.3.1.1 – Special Processing Instructions and Considerations for the Initial Review Process

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Form CMS-855A – Old and New Owner Applications

Unless stated otherwise in this chapter:

- The contractor shall ensure that all applicable sections of the Form CMS-855A for both the old and new owner are completed in accordance with the instructions on the Form CMS-855A.

- The instructions in this section 10.6.1.1.3.1.1(A) apply only to the Form CMS-855A.

1. Previous Owner(s)

The previous owner's Form CMS-855A CHOW application does not require a recommendation for approval. Any recommendations will be based on the CHOW application received from the new owner.

If the previous owner's Form CMS-855A is available at the time of review, the contractor shall examine the information therein against the new owner's Form CMS-855A to ensure consistency (e.g., same names). If the previous owner's Form CMS-855A has not been received, the contractor shall contact the previous owner and request it. However, the contractor may begin processing the new owner's application without waiting for the arrival of the previous owner's application. It may also make its CHOW recommendation to the state without having received the previous owner's Form CMS-855A.

If a certification statement is not on file for the individual signing the previous owner's application, the contractor shall request that the Individual Ownership and/or Managing Control section of the Form CMS-855A be completed for said person.

Note that the previous owner's Form CMS-855A CHOW application is essentially the equivalent of a Form CMS-855A voluntary termination submission; this is because the old owner is voluntarily leaving the Medicare program. As such, the contractor shall not require the old owner to submit a separate Form CMS-855A voluntary termination along with its Form CMS-855A CHOW application.

2. New Owner

If a Form CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's Form CMS-855A, the contractor shall contact the new owner. If, within

30 calendar days after the contractor contacted it, the new owner fails to (1) submit a Form CMS-855A and (2) indicate that it accepts assignment of the provider agreement, the contractor shall send an e-mail to its PEOG BFL notifying him/her of the situation. PEOG will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

In the situations described in the previous paragraph where the contractor is awaiting the new owner's application after received the old owner's, the contractor shall: (1) begin processing the old owner's application; and (2) if possible, ascertain whether a CHOW has taken place.

3. Order of Processing of Old/New Owner Applications

To the maximum extent practicable, Form CMS-855A applications from the previous and new owners in a CHOW should be processed as they arrive. However, unless the instructions in this chapter indicate otherwise, the contractor should attempt to send the previous and new owners' applications to the state simultaneously, rather than as soon as they are processed. For instance, suppose the previous owner submits an application on March 1. The contractor should begin processing the application immediately without waiting for the arrival of the new owner's application. Yet the contractor should avoid sending the previous owner's application to the state until the new owner's application is processed. (For acquisition/mergers and consolidations (as those terms are described on the Form CMS-855A), the contractor may send the applications to the state separately.)

4. Form CMS-855A: CHOWs Involving Subtypes

a. Separate Reporting

Any subunit that has a separate provider agreement must report its CHOW on a separate Form CMS-855A. It cannot report the CHOW via the main provider's Form CMS-855A. If the subunit does not have a separate provider agreement (e.g., hospital psychiatric unit), the CHOW can be disclosed on the main provider's Form CMS-855A; this is because the subunit is a practice location of the main provider and not a separately enrolled entity.

b. Change in Subtype

A CHOW may occur in union with a change in the facility's provider subtype. This can happen, for instance, when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information (COI), the provider need not submit separate applications – one for the COI and one for the CHOW. Instead, all information (including the change in hospital type) should be reported on the CHOW application; the entire application should then be processed as a CHOW (assuming it indeed qualifies as such). However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment. The contractor shall notify the provider of this and return the application.

(NOTE: For Medicare purposes, a critical access hospital (CAH) is a separately-recognized provider type. Thus, a general hospital undergoing a CHOW while converting to a CAH must submit its Form CMS-855A as an initial enrollment, not as a CHOW.)

5. Transitioning to Provider-Based Status (Form CMS-855A Submissions Only)

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR § 489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the old and new owner's Form CMS-855A applications. Should the "old/previous" (or current) contractor receive the old and/or new owner's Form CMS-855A applications, it shall (a) forward the application to the new contractor within 5 business days of receipt and (b) notify the new contractor within that same timeframe that the application was sent.

B. Sales and Lease Agreements

Except as indicated otherwise, this subsection (B) applies to Form CMS-855A and Form CMS-855B applications.

1. Verification of Terms

The contractor shall ascertain whether: (1) the sales/lease agreement includes the signatures of the old and new owners, for the agreement must contain the signatures of both parties to the transaction (if it does not, the contractor shall develop for an agreement containing both signatures); (2) the information contained in the sales agreement is consistent with that reported on the new owner's Form CMS-855A or the submitted Form CMS-855B (e.g., same names, effective date); (3) the terms of the contract indicate that the new owner will accept assignment of the provider agreement; and (4) the transaction falls within the scope of organizational transactions covered under § 489.18 and this section 10.6.1.1 et seq.

(Note that a bill of sale/lease agreement/sales transfer agreement is a sales/lease business document and should not be confused with a patient transfer agreement.)

A sales/lease agreement often will not specifically refer to the Medicare provider agreement, assets, and liabilities. However, if (1) the box in the Change of Ownership (CHOW) Information section of the Form CMS-855A is checked "Yes" and (2) the sales/lease agreement either confirms that the new owner will accept assignment or is relatively silent on the matter, the contractor can proceed as normal. If the agreement indicates that assignment will not be accepted, however, the contractor shall follow the instructions in section 10.6.1.1.3.2(A) below.

As previously mentioned, any clarifying data must be furnished in writing (e.g., additional legal documentation, letter, e-mail). If the clarification – for whatever reason - requires an update to the supplier's Form CMS-855 application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the Form CMS-855, the contractor shall seek clarifying information and, if necessary, obtain an updated Form CMS-855.

2. Form of Sales/Lease Agreement

There are instances where the parties in a CHOW did not sign a "sales" or "lease" agreement in the conventional sense of the term; the parties, for example, might have documented their agreement via a "bill of sale." The contractor can accept such documentation in lieu of a sales/lease agreement so long as (1) the document addresses the transaction's terms and (2) the information in the agreement is consistent with that on the Form CMS-855 (as discussed above).

3. Submission of Sales/Lease Agreement

a. General Requirements – Unless specified otherwise in this chapter: (i) both the previous and new owners in a Form CMS-855A CHOW situation must submit copies of the interim and final sales/lease agreements; and (ii) copies of the interim and final sales/lease agreement must be submitted in Form CMS-855B CHOW situations.

b. Forwarding to State - The contractor shall not forward a copy of the application to the state until it has received and reviewed the final sales/lease agreement. However, the contractor need not reverify the information on the Form CMS-855 while waiting for the final agreement, even if the data therein may be somewhat outdated by the time the final agreement is received.

c. Failure to Submit - If a final sales/lease agreement is not submitted within 30 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 30th day to reject the application, the contractor may proceed with rejection regardless of how many times it contacted the new owner or what types of responses (short of the actual receipt of the agreement) were received.

C. Relocation of Entity

A new owner may intend to relocate the provider concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the state via e-mail immediately. If the state believes that this situation has resulted in the effective creation of a new provider, the contractor shall return the application and notify the new owner that a new, initial enrollment application must be submitted. The provider must also notify the state or, if applicable, accreditation agency.

D. Intervening Change of Ownership

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

Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval to the state has not yet been made for the initial application: The contractor shall return both applications and require the provider to re-submit an initial application with the new owner's information.

Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval to the state has not yet been made for the first CHOW application: The contractor shall process both applications – preferably in the order they were received – and shall, if recommendations for approval are warranted, refer both applications to the state in the same package. The accompanying notice/letter to the state shall explain the situation.

Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made to the state – The contractor shall:

- Return the CHOW application.

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

- Request via letter that the provider 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 provider fails to do so, the contractor shall return the originally submitted initial application and notify the provider and the state of this via letter. If the provider submits the requested application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the state with an explanation of the situation; 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 provider and the state accordingly.

Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

- Notify the state 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 provider to resubmit a new CHOW application containing the subsequent/second new owner's information.

- Process the new/second CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the state with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted/second CHOW application is returned per section 10.6.1.1.3.2 below, the first application should, too, be returned. The contractor shall notify the provider and the state accordingly.

E. **Potential CHOW**

On occasion, a provider or supplier submits a Form CMS-855 change of information to report a large-scale stock transfer or other significant ownership change that the provider does not believe is (or report as) a CHOW. If the contractor suspects that the transaction in question might indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).

F. **Entry into PECOS -** ***Paper Applications Only***

If it appears that the new owner will be accepting assignment and that the transaction falls within the scope of § 489.18, the contractor shall enter the CHOW information into the new enrollment record that shall be created for the new owner. (If the state recommends approval of the CHOW (see section 10.6.1.1.3.3 below), the Part A provider's CCN will be maintained in the new owner's enrollment record once the record is switched to an approved status.)

A new enrollment record must be created if a new TIN is established pursuant to the CHOW.

(For PECOS applications, PECOS will automatically perform the enrollment record activities described in this subsection (F).)

10.6.1.1.4 – Additional CHOW Processing Policies

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Except as otherwise stated, the instructions in this section 10.6.1.1.4 apply to the Form CMS-855A and Form CMS-855B.

A. Payment Changes - In a CHOW, the contractor shall continue to pay the old owner until it receives from PEOG the e-mail, effective date, and signed provider agreement referenced in Section 10.6.1.1.3.3(B). Hence, any application from the old owner or new owner to change the EFT account or special payment address to that of the new owner shall be

returned. It is ultimately the responsibility of the old and new owners to coordinate any payment arrangements between themselves while the contractor and the state are reviewing the CHOW. It is recommended that the contractor notify the new owner of this while processing the application.

B. National Provider Identifiers (NPI) - Depending on the sale's terms, the new owner may obtain a new NPI or maintain the existing NPI. Once CHOW processing is complete, the old owner is prohibited from billing for services (i.e., services furnished after CHOW processing is complete); only the new owner may submit claims using the existing CCN. As already stated, the old owner and new owner must arrange between themselves any payment matters regarding claims for services furnished during the CHOW processing period.

C. CHOW Pre-Approval Changes of Information

1. Old Owner

If – prior to receiving an approval recommendation from the state -– the contractor receives from the old owner a Form CMS-855 request to change any of the provider's enrollment data, the contractor shall return the change request if the information involves changing the provider's:

i. EFT or special payment address information to that of the new owner (as described in section 10.6.1.1.4(A) above);

ii. Practice location or base of operations to that of the new owner;

iii. Ownership or managing control to that of the new owner;

iv. Legal business name, TIN, or "doing business as" name to that of the new owner.

All other "pre-state recommendation" Form CMS-855 change requests from the old owner can be processed normally.

2. New Owner

If – prior to receiving an approval recommendation from the state - the contractor receives from the new owner a Form CMS-855 request to change any of the provider/supplier's existing enrollment information, the contractor shall return the change request. This is because the old owner remains the owner of record at this time; the new owner therefore has no standing to submit Form CMS-855 changes on behalf of the provider.

D. Change of Transaction Type in PECOS - There may be instances where the contractor enters a transaction into PECOS as a CHOW, but it turns out that the transaction was not a CHOW (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept assignment). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; however, it should note in *PECOS* that the transaction was not a CHOW.

E. Unreported CHOW - If the contractor learns via any means (including from the state or SOG Location) that an enrolled provider has been purchased by another entity or has purchased another Medicare-enrolled provider, the contractor shall immediately request Form CMS-855A CHOW applications from both the previous and new owners (or request a Form CMS-855B CHOW application from the ASC or PXRS). If the new owner fails to submit a Form CMS-855 within the latter of (1) the date of acquisition or (2) 30 days after the request, the contractor shall send an e-mail to its PEOG BFL notifying him/her of the situation. PEOG

will determine whether the provider's billing privileges should be deactivated under § 424.540(a)(2) or § 424.550(b) or revoked under § 424.535(a)(1) or (a)(9). PEOG will notify the contractor of its decision.

F. Precise Time of CHOW - In general, a Medicare CHOW is considered to have taken place at 12:01 a.m. on the date specified (i.e., in the first minute of the 24-hour day). Legal responsibility and the right to payment changes when the clock moves past midnight into the CHOW effective date.

G. Termination of CCN - If the new owner rejects assignment, the CCN associated with that agreement (the old owner's) also terminates on the date of the ownership transfer.

H. Clock Stoppages and Processing Alternatives - While awaiting PEOG's reply on any matter in this section 10.6.1.1 et seq. 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 10.6.1.1 et seq. negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.1 et seq.

10.6.1.3 – Voluntary Terminations

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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.

Except as stated otherwise in this chapter, this section does not apply to voluntary terminations pursuant to an HHA change in majority ownership under § 424.550(b)(1). Instructions concerning the handling of these transactions are in section 10.2.1.6.1 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 *unless a Form CMS-855 was submitted via PECOS; in this latter case, the contractor shall process the Form CMS-855 rather than the letter*. 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 *unless a Form CMS-855 was submitted via PECOS; in this latter case, the contractor shall process the Form CMS-855*. 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.)

1. 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).

(ii) 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) 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 – 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. State Agency Performs Survey Based on Cessation of Business

(i) Solicitation of Information

Situations 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 day before the date of the sale. For certified suppliers paid via MCS, however, the deactivation effective date shall be the date of the sale. (Note that this paragraph (9)(c) does not apply to HHA changes in majority ownership for which no exception applies; see section 10.2.1.6.1(B) of this chapter for more information.)

10.6.2 – Establishing Effective Dates

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

In reviewing this section 10.6.2, it is important that the contractor keep in mind the distinctions between: (1) the date of enrollment/approval; (2) the effective date of billing privileges under 42 CFR § 424.520(d); and (3) the date from which the supplier may retrospectively bill for services under § 424.521(a).

(Note that the date of receipt of a PECOS application is the date on which the contractor received it, not the date on which the application required the contractor's manual intervention per section 10.3.)

A. Date of Enrollment/Approval

For suppliers other than ambulatory surgical centers and portable x-ray suppliers, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose a practitioner met all the requirements needed to enroll in Medicare (other than the submission of a Form CMS-855I) on January 1. He submits his Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1.

B. Establishing Effective Dates of Billing Privileges for Certain Suppliers Under 42 CFR § 424.520(d)

1. Applicability

This section 10.6.2(B) applies to the following individuals and organizations:

a. Physicians; physician assistants; nurse practitioners; audiologists; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; independently billing psychologists, registered dietitians or nutrition professionals; physical therapists; occupational therapists; speech-language pathologists; and physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above.

b. Ambulance suppliers

c. Part B hospital departments

d. CLIA labs

e. Opioid treatment programs.

f. Mammography centers

g. Mass immunizers/pharmacies

h. Radiation therapy centers

i. Home infusion therapy suppliers

(See 42 CFR §§ 424.520(d)(2) and 424.521(a)(2) for the regulatory listing of these providers/suppliers.)

2. Background

In accordance with 42 CFR § 424.520(d)(1), the effective date of billing privileges for the individuals and organizations identified in § 424.520(d)(2) (and section 10.6.2(B)(1) above) is the later of:

(i) The date the supplier filed an enrollment application that was subsequently approved, or

(ii) The date the supplier first began furnishing services at a new practice location.

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

3. Retrospective Billing Under 42 CFR § 424.521(a)

Consistent with 42 CFR § 424.521(a)(1), the individuals and organizations identified in § 424.521(a)(2) (and section 10.6.2(B)(1) above) may retrospectively bill for services when:

(i) The supplier has met all program requirements, including state licensure requirements; and

(ii) The services were provided at the enrolled practice location for up to—

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

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

The contractor shall interpret the aforementioned phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements (including state licensure) during the 30-day period before an application was submitted and no final adverse action (as that term is defined in § 424.502) precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved--so long as it is not more than 30 days prior to the date on which the application was submitted.

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

4. Summarizing the Distinction Between Effective Date of Billing Privileges and Retrospective Billing Date

As already discussed, the effective date of billing privileges is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a Form CMS-855I initial enrollment application on May 1. The application is approved on June 1 (which, as discussed in section 10.6.2(A) above, is the date of enrollment). The physician's effective date of billing privileges is May 1, which is the later of: (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 1 (or 30 days prior to the effective date of billing privileges), assuming that the requirements of 42 CFR § 424.521(a) are met. The effective date entered into PECOS and the Multi-Carrier System will be April 1; claims submitted for services provided before April 1 will not be paid.

C. Effective Date of Reassignment

Per 42 CFR § 424.522(a), the effective date of the reassignment is 30 days before the Form CMS-855R is submitted if all applicable requirements during that period were otherwise met. The contractor shall apply this policy in the following manner:

1. Form CMS-855R submitted as "stand-alone" without Form CMS-855I – The effective date in § 424.522(a) applies to the reassignment unless the effective date that the supplier listed on the Form CMS-855R is later than what the § 424.522(a) date is, in which case the Form CMS-855R-listed effective date controls.

2. Form CMS-855R submitted with Form CMS-855I either simultaneously or as part of development (e.g., physician only submits Form CMS-855I and contractor develops for Form CMS-855R) – The contractor shall apply the Form CMS-855I effective date (per 42 CFR §§ 424.520(d) and 424.521(a)) to the Form CMS-855R. When one or both of these forms requires the contractor to develop for information – and for purposes of establishing the §§ 424.520(d)/424.521(d) effective date -- the contractor may apply the receipt date of the first application that is submitted as complete (i.e. no further development is necessary).

3. Form CMS-855R submitted with Form CMS-855B either simultaneously or as part of development – The contractor shall apply the Form CMS-855B effective date (per 42 CFR §§ 424.520(d) and 424.521(a)) to the Form CMS-855R. When one or both of these forms requires the contractor to develop for information – and for purposes of establishing the §§ 424.520(d)/424.521(d) effective date -- the contractor may apply the receipt date of the first application that is submitted as complete (i.e. no further development is necessary).

Notwithstanding the foregoing, the contractor shall apply the 90-day retroactive billing period referenced in subsection 10.6.2(B)(3)(ii)(B) above to the Form CMS-855R submissions described in this subsection (C) in the event of a Presidentially-declared disaster under the Stafford Act).

D. Effective Date for Certified Providers and Certified Suppliers

Note that 42 CFR § 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met; and (2) such requirements include the contractor's review and verification of an application to enroll in Medicare.

E. Effective Date for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Per § 424.57(b), DMEPOS suppliers must meet, among other requirements, the following conditions in order to be eligible to receive payment for a Medicare-covered item:

(1) The supplier has submitted a completed application to CMS to furnish Medicare-covered items including required enrollment forms. (The supplier must enroll separate physical locations it uses to furnish Medicare-covered DMEPOS, with the exception of locations that it uses solely as warehouses or repair facilities.)

(2) The item was furnished on or after the date CMS issued to the supplier a DMEPOS supplier number conveying billing privileges. (CMS issues only one supplier number for each location.) This requirement does not apply to items furnished incident to a physician's service.

The contractor shall indicate the supplier's status as approved in PECOS upon the contractor making the determination the supplier meets all of the supplier standards found at § 424.57(c). The date the supplier was approved in PECOS shall be the supplier's effective date.

F. Form CMS-855O Effective Dates

Notwithstanding any other instruction in the chapter to the contrary, the effective date of a Form CMS-855O enrollment per 42 CFR § 424.522 is the date on which the Medicare contractor received the Form CMS-855O application if all other requirements are met --- meaning the Form CMS-855O was processed to approval.

G. Effective Date for Medicare Diabetes Prevention Program (MDPP) Suppliers

In accordance with 42 CFR § 424.205(f), the effective date of billing privileges for MDPP suppliers is the later of:

- The date the supplier filed an enrollment application that was subsequently approved,
- The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
- The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number. *(For PECOS applications, see section 10.3 of this chapter for information about what constitutes an enrollment record in PECOS.)*

Under no circumstances should an effective date for billing privileges be prior to April 1, 2018. For any Form CMS-20134 submitted prior to April 1, 2018 and subsequently approved, the contractor shall note April 1, 2018 as the MDPP supplier's effective date, even if this date is in the future.

NOTE: The date of filing for paper Form CMS-20134 applications is the date on which the contractor received the application. For Internet-based PECOS applications, the date of filing is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

H. Future Effective Dates

If the contractor cannot enter an effective date into PECOS because the provider/supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider/supplier and the effective date are established (e.g., *notification from the state* is received), the contractor shall change the effective date in PECOS.

10.6.5 – National Provider Identifier (NPI)

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Submission of NPI

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the Form CMS-855 or CMS-20134. The provider need not submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES) *because PECOS will verify the NPIs of the provider/supplier and all other NPIs listed on the application.*

B. Additional NPI Information

The contractor shall only enter NPI data into PECOS that is submitted in conjunction with a Form CMS-855 or CMS-20134 (e.g., initial, change request). Thus, if a provider submits a Form CMS-855 or CMS-20134 change of information that only reports the provider's newly assigned NPI, or reports multiple NPIs that need to be associated with a single Medicare identification number, the contractor may treat this as a change request and enter the data into PECOS.

C. Subparts - General

The contractor shall review and become familiar with the principles outlined in the "Medicare Expectations Subpart Paper," the text of which follows below. It was originally issued in January 2006 and has since been slightly updated to reflect certain changes in Medicare terminology.

CMS encourages all providers to obtain NPIs in a manner similar to how they receive CMS Certification Numbers (CCNs) (i.e., a "one-to-one relationship"). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider and the branch will typically receive separate (albeit very similar) CCNs. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each CCN.

D. Medicare Subparts Paper - Text

MEDICARE EXPECTATIONS ON DETERMINATION OF SUBPARTS BY MEDICARE ORGANIZATION HEALTH CARE PROVIDERS WHO ARE COVERED ENTITIES UNDER HIPAA

Purpose of this Paper

Medicare assigns unique identification numbers to its enrolled health care providers. They are used to identify the enrolled health care providers in the HIPAA standard transactions that they conduct with Medicare (such as electronic claims, remittance advices, eligibility

inquiries/responses, claim status inquiries/responses, and coordination of benefits) and in cost reports and other non-standard transactions.

This paper is a reference for Medicare contractors. It reflects the Medicare program's expectations on how its enrolled organization health care providers that are covered entities under HIPAA1 will determine subparts and obtain NPIs for themselves and any subparts. These expectations may change over time to correspond with any changes in Medicare statutes, regulations, or policies that affect Medicare provider enrollment.

These expectations are based on the NPI Final Rule, on statutory and regulatory requirements with which Medicare must comply, and on policies that are documented in Medicare operating manuals and other directives. These Medicare statutes, regulations and policies pertain to conditions for provider participation in Medicare, enrollment of health care providers in Medicare and assignment of identification numbers for billing and other purposes, submission of cost reports, calculation of payment amounts, and the reimbursement of enrolled providers for services furnished to Medicare beneficiaries.

This paper categorizes Medicare's enrolled organization health care providers as follows:

- Certified providers and certified suppliers
- Supplier groups and supplier organizations
- Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

This paper is not intended to serve as official HHS guidance to the industry in determining subparts for any covered health care providers other than those that are organizations and are enrolled in the Medicare program. This paper does not address health care providers who are enrolled in Medicare as individual practitioners. These practitioners are Individuals (such as physicians, physician assistants, nurse practitioners, and others, including health care providers who are sole proprietors). In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI. As Individuals, these health care providers cannot be subparts and cannot designate subparts. A sole proprietorship is a form of business in which one person owns all of the assets of the business and the sole proprietor is solely liable for all of the debts of the business. There is no difference between a sole proprietor and a sole proprietorship. In terms of NPI assignment, a sole proprietor/sole proprietorship is an Entity Type 1 (Individual) and is eligible for a single NPI. As an Individual, a sole proprietor/sole proprietorship cannot have subparts and cannot designate subparts.

Discussion of Subparts in the NPI Final Rule and its Applicability to Enrolled Medicare Organization Health Care Providers

The NPI Final Rule adopted the National Provider Identifier (NPI) as the standard unique health identifier for health care providers for use in HIPAA standard transactions. On or before May 23, 2007, all HIPAA covered entities (except small health plans), to include enrolled Medicare providers and suppliers that are covered entities, were required to obtain NPIs and to use their NPIs to identify themselves as "health care providers" in the HIPAA standard transactions that they conduct with Medicare and other covered entities. Covered organization health care providers are responsible for determining if they have "subparts" that

[1] Covered entities under HIPAA are health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a health transaction for which the Secretary of HHS has adopted a standard (referred to in this paper as HIPAA standard transactions). Most Medicare Organization health care providers send electronic claims to Medicare (they are HIPAA standard transactions), making them covered health care providers (covered entities).

need to have NPIs. If such subparts exist, the covered organization health care provider must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

The NPI Final Rule contains guidance for covered organization health care providers in determining subparts. Subpart determination is necessary to ensure that entities within a covered organization health care provider that need to be uniquely identified in HIPAA standard transactions obtain NPIs for that purpose.

The following statements apply to **all** entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)

- A subpart furnishes health care as defined at 45 CFR § 160.103.

The following statements may relate to some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.

- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

- Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. Medicare covered organization health care providers must take any such statutes or regulations into account to ensure that, if Medicare providers are uniquely identified now by using Medicare identifiers in HIPAA standard transactions, they obtain NPIs in order to ensure they can continue to be uniquely identified. Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions (for organizations, these could be CCNs, Provider Transaction Access Numbers (PTANs)—known as legacy identifiers or legacy numbers) to NPIs. This makes it necessary that Medicare organization health care providers obtain NPIs because the NPIs have replaced the identifiers currently in use in standard transactions with Medicare and with all other health plans. In addition, Medicare organization health care providers must determine if they have subparts that need to be uniquely identified for Medicare purposes (for example, in HIPAA standard transactions conducted with Medicare). If that is the case, the subparts will need to have their own unique NPIs so that they can continue to be uniquely identified in those transactions.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Enrolled Medicare organization health care providers that are covered entities under HIPAA must apply for NPIs as Organizations (Entity Type 2). Organization health care providers as discussed in this paper are corporations or partnerships or other types of businesses that are considered separate from an individual by the State in which they exist. Subparts of such organization health care providers who apply for NPIs are also Organizations (Entity Type 2).

Medicare Statutes, Regulations, Manuals

The Social Security Act (sections 1814, 1815, 1819, 1834, 1861, 1865, 1866, and 1891) and Federal regulations (including those at 42 CFR 400.202, 400.203, 403.720, 405.2100, 409.100, 410.2, 412.20, 416.1, 418.1, 424, 482.1, 482.60, 482.66, 483, 484, 485, 486, 489, 491, and 493.12) establish, among other things, the Conditions for Participation for Medicare providers and set requirements by which Medicare enrolls providers, requires cost reports, calculates reimbursement, and makes payments to its providers. These Medicare statutory and regulatory requirements are further clarified in various Medicare operating manuals, such as the State Operations Manual and the Program Integrity Manual, in which requirements and policies concerning the assignment of unique identification numbers, for billing and other purposes, are stated.

Medicare Organization Providers and Subparts:
Certified Providers and Certified Suppliers

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to Medicare certified providers and certified suppliers for billing purposes.

Certified Providers that bill Medicare Part A (hereinafter referred to as "providers"):

- Providers apply for Medicare enrollment by completing a Form CMS-855A.

- Most providers are surveyed and certified by the States[3] prior to being approved as Medicare providers.[2]

- Providers have in effect an agreement to participate in Medicare.

- Providers include, but are not limited to: skilled nursing facilities, hospitals[4,] critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.

- Providers are assigned CCNs to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.

- In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (One exception involves home health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

Certified Suppliers, which bill Medicare Part B:

- Certified suppliers apply for Medicare enrollment by completing a Form CMS-855A or CMS-855B, depending on the supplier type.[3]

- Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.

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[2] Religious non-medical health care institutions are handled differently.
[3] Hospitals bill Medicare Part B for certain types of services. [4] The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.

- Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)

- Certified suppliers may have in effect an agreement to participate in Medicare.

- Certified suppliers are assigned CCNs for purposes of identification within Medicare processes. However, the contractors assign unique identification numbers to certain certified suppliers for billing purposes. (For CLIA labs, a CLIA number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA number may not be used to identify a clinical laboratory as a "health care provider" in HIPAA standard transactions. The CLIA number has no relation to the Medicare PTAN.)

- In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

In general, Medicare bases its enrollment of providers and certified suppliers on two main factors: (1) whether a separate State certification or survey is required, and (2) whether a separate provider or certified supplier agreement is needed. (The Taxpayer Identification Number, or TIN, is a consideration as well, though not to the degree of the two main factors.) The CMS *Survey & Operations Group (SOG) Location* generally make the final determinations on both of these factors; hence, Medicare provider and certified supplier enrollment policy is dictated to a significant degree by the CMS regional offices' decisions in particular cases.

Medicare Expectations for NPI Assignments for Providers and Certified Suppliers: To help ensure that Medicare providers and certified suppliers do not experience denials of claims or delays in Medicare claims processing or reimbursement, Medicare encourages each of its enrolled providers and certified suppliers to obtain its own unique NPI. These NPIs have replaced the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports. In order for subpart determinations to mirror Medicare enrollment, each enrolled provider and certified supplier that is a covered organization health care provider should:

- Obtain its own unique NPI.

- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, a total of 11 unique NPIs should be obtained: one for the hospital, and one for each of the 10 home health agencies.

Regardless of how an enrolled provider or certified supplier that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled provider or certified supplier.

Medicare Organization Providers and Subparts: Supplier Groups and Supplier Organizations

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to supplier groups and supplier organizations for billing purposes.

- Supplier groups and supplier organizations apply for Medicare enrollment by completing a Form CMS-855B or CMS-20134.

- Supplier groups and supplier organizations bill Medicare Part B.

- Certain supplier organizations are certified by the States, certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the contractor. These requirements vary by type of supplier organization.

    - Supplier groups are primarily group practices, such as a group of physicians or other practitioners.

    - Supplier organizations include ambulance companies, mammography facilities, independent diagnostic testing facilities (IDTFs) and MDPP Suppliers.

Medicare enrolls supplier groups/supplier organizations based on TINs. A supplier group or supplier organization may have multiple locations; however, if each location operates under the same single TIN, Medicare does not separately enroll each location. There are exceptions:

1. When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a Form CMS-855B and the IDTF would complete a Form CMS-855B. Each one would receive its own unique Medicare identification number.

2. If a separate site visit, *s*tate certification, or on-site inspection by the contractor or if FDA certification is required for each practice location of that supplier group/supplier organization.

In these above exceptions, Medicare separately enrolls each different Medicare specialty and each separately visited, certified or contractor-inspected practice location.

Medicare Expectations for NPI Assignments for Supplier Groups and Supplier Organizations: To help ensure that Medicare supplier groups and supplier organizations do not experience delays in Medicare claims processing or reimbursement, Medicare encourages each of its enrolled supplier groups and supplier organizations to obtain its own unique NPI. These NPIs have replaced the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports. In order for subpart determinations to mirror Medicare enrollment, each enrolled supplier group and supplier organization that is a covered organization health care provider should ensure the following:

- Obtain its own unique NPI.

- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them.

EXAMPLE: An enrolled IDTF has four different locations, and each one must be separately inspected by the contractor. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, a total of four unique NPIs should be obtained: one for each location.

Regardless of how an enrolled supplier group or supplier organization that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled supplier group or supplier organization.

Medicare Organization Providers and Subparts: DMEPOS Suppliers

Medicare regulations require that each practice location of a supplier of DMEPOS (if it has more than one) must, by law, be separately enrolled in Medicare and have its own unique Medicare identification number.

- A supplier of DMEPOS enrolls in Medicare by completing a Form CMS-855S.
- Suppliers of DMEPOS bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs).
- Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies. (Any organization that sells equipment or supplies that are billed to Medicare through the DME MAC must be enrolled as a supplier of DMEPOS *via the appropriate NPE contractor*. Sometimes, these are organizations that also furnish services that are covered by Medicare, such as ambulatory surgical centers. In order to be reimbursed for the DME supplies that they sell, they must separately enroll in Medicare as a supplier of DME.)

Medicare Expectations for NPI Assignments for Suppliers of DMEPOS: Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI.

Final Notes About NPIs

Enrolled organization health care providers or subparts that bill more than one Medicare contractor: An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor. For example, a physician group practice billing Contractor X and also billing Contractor Y would use a single (the same) NPI to bill both contractors.

Enrolled organization health care providers or subparts that bill more than one type of Medicare contractor: Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor that processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type of Medicare contractor. However, in certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as more than one type of provider. For example, an ambulatory surgical center enrolls in Medicare as a certified supplier and bills a Part A/B MAC. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a *s*upplier of DME and bill a DME MAC. This ambulatory surgical center would obtain a single NPI and use it to bill the A/B MAC and the DME MAC. Medicare expects that this ambulatory surgical center would report two different Taxonomies when it applies for its NPI: (1) that of ambulatory health care facility—clinic/center--ambulatory surgical (261QA1903X) and (2) that of suppliers—durable medical equipment & medical supplies (332B00000X) **or** the appropriate sub-specialization under the 332B00000X specialization.

Enrolled organization health care providers that determine subparts for reasons unrelated to Medicare statutes, regulations or policies:

Consistent with the NPI Final Rule, covered organization health care providers designate subparts for reasons that are not necessarily related to Medicare statutes or regulations. If a Medicare organization health care provider designates as subparts entities other than those that are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, those NPIs will not identify enrolled Medicare providers. Medicare is not required to enroll them. (NPI Final Rule, page 3441: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls."))

Medicare uses NPIs to identify health care providers and subparts in HIPAA standard transactions. (NPI Final Rule, page 3469: section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.") Medicare ensures that the NPIs it receives in HIPAA standard transactions are valid[5]. Medicare rejects HIPAA standard transactions that contain invalid NPIs. Valid NPIs, however, like the provider identifiers used today, must be "known" to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers, nor is it permitted to reimburse providers that are not enrolled in the Medicare program. Medicare returns, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.[4]

10.6.10 – Medicare Payment

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Electronic Fund Transfers (EFT)

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 *PECOS applications,* the Form CMS-588 shall be submitted via PECOS.

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[4] The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.

The contractor shall also follow the EFT instructions in sections 10.3(C)(2) and 10.6.23 of this chapter.

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

1. Paper Applications - 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.

2. PECOS Applications – See section 10.3 of this chapter for information regarding the issuance of PTANs

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.

10.6.13 – Ordering/Certifying Suppliers

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Ordering/Certifying Suppliers– Background

1. Who Can Order/Certify

Pursuant to CMS Final Rule 6010-F (published April 27, 2012), to order or certify for Medicare items and services, a provider or supplier must be enrolled (i.e., in an approved or valid opt-out status) in PECOS.

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

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry

- Doctors of optometry
- Physician assistants
- Certified clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Certified nurse midwives
- Clinical social workers
- Residents meeting eligibility criteria (Pursuant to CMS Final Rule CMS-6010-F, residents (as defined in 42 CFR § 413.75 and which includes interns and fellows) who are enrolled in an accredited graduate medical education program in a state that licenses or otherwise enables such individual to practice or order these items or services may enroll in Medicare to order and certify).

Most physicians and non-physician practitioners enroll in Medicare so they can receive reimbursement for covered services to Medicare beneficiaries. However, some physicians and non-physician practitioners who are not enrolled in Medicare via the Form CMS-855I may wish to order or certify items or services for Medicare beneficiaries. These individuals can become eligible to do so by completing the Form CMS-855O via paper or *PECOS*.

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

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

B. Requirements for Suppliers to Maintain Ordering and Certifying Documentation

1. Background

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

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

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

In addition, under § 424.516(f)(2), a physician who orders/certifies home health services and the physician - or, when permitted, other eligible professional - who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke enrollment under § 424.535(a)(10).

2. Contractors Requests for Documentation of Ordering or Certifying

Absent a CMS directive to the contrary, the contractor shall request the documentation described in subsection (A) if it has reason to believe that the provider, supplier, physician, or *other* eligible professional (hereinafter collectively referred to as "provider") is not maintaining the documentation in accordance with § 424.516(f)(1) or (2). Examples of when a request might be appropriate include, but are not limited to:

- The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has generated an alert with respect to the provider.
- The provider has been the subject of a recent Unified Program Integrity Contractor referral.
- The provider maintains an elevated surety bond amount.

These are, of course, only examples of when a request could perhaps be warranted. Ultimately, the contractor would have to consider the surrounding circumstances of each case, including those involving situations not addressed in the aforementioned examples. The contractor may always contact its PEOG BFL if it is uncertain as to whether a particular documentation request should be made.

NOTE: Documentation cannot be requested for written orders and certifications dated prior to July 6, 2010.

3. Requirement for Providers and Suppliers to Maintain and Provide Access to Documentation

Under § 424.516(f), CMS or a Medicare contractor may request access to documentation described in §424.516(f). The term "access to documentation" means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor. All providers and suppliers who either furnish, order, or certify the items described in section 10.6.13(B)(1) are subject to this requirement and are individually responsible for maintaining these records and providing them upon request.

For example, if a Medicare contractor requests copies of all orders for wheelchairs from an ordering physician for all beneficiaries with dates of service from November 1, 2014 through November 10, 2014, the ordering physician must provide the copies, in full, according to the specific request. If copies cannot be provided because the physician or *other* eligible professional did not personally maintain the records or can only be partially provided, then the requirement to maintain this documentation and provide access to it will not have been met and the provider, supplier, physician, or *other* eligible professional may be *revoked under* § 424.535(a)(10).

Examples of Sufficient and Deficient Access may include, but are not limited to:

Sufficient Access:

- All documentation requested
- Documentation specific to the order(s) or certification(s), as requested
- Documentation for the dates of service or billing periods requested

Deficient Access

- Providing none of the requested documentation
- Providing none of the requested documentation
- Providing similar documentation that does not contain the order or certification requested
- Providing other documents NOT requested by CMS or a Medicare contractor and/or not specifically directing attention to the requested documentation

The CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf. However, it remains the responsibility of the individual or entity *to* whom/which the request has been made to provide documentation. All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with *non-compliance* with the documentation request.

4. Process to Request Documentation of Ordering or Certifying

If the contractor believes that a request for documentation is warranted, it shall prepare and send a request letter (refer to model letters at the end of this chapter) to the provider via certified mail. If the provider:

- Fails to respond within 30 calendar days of the contractor's request (i.e., a complete non-response), the contractor shall revoke enrollment using § 424.535(a)(10) as the basis. Prior approval from the contractor's PEOG BFL is not necessary. A 1-year re-enrollment bar shall be imposed.

- Timely furnishes documentation that the contractor nevertheless deems inadequate, the contractor shall send a developmental letter via mail, *the PCV,* e-mail, or fax to the provider that requests more sufficient documentation. If the provider fails to submit such documentation (either via a complete non-response or by submitting additional inadequate documentation), the contractor shall refer the matter (including the documentation submitted to date) to its PEOG BFL. CMS will determine whether a revocation is warranted and will notify the contractor via e-mail of its decision.

- Furnishes documentation that the contractor deems adequate, the contractor need not take further action other than to *upload* the documentation and the documentation request letter(s) in *PECOS.*

5. Additional Guidance Regarding Documentation of Ordering or Certifying

The contractor shall also abide by the following:

a. When preparing the letter referred to in section 10.6.13(B)(4) above, the contractor shall use the appropriate model language in section 10.7.17 and 10.7.17 (A) of this chapter. Note, however, that while the letters request copies of orders, the contractor has the discretion to ask for different or additional documentation (e.g., documentation that supports the legitimacy of a particular service or the payment of a particular claim). Copies of orders need not be requested in every situation. As alluded to in section 10.6.13(B)(2) above, the contractor would have to examine the facts of each case in determining the type(s) of documentation to be requested.

b. There may be situations in which CMS directs the contractor to request documentation in a particular case. The contractor shall follow the instructions in this section 10.6.13(B) with respect to doing so.

c. The contractor shall contact its CMS PEOG BFL if it has questions as to whether particular submitted documentation is adequate or legitimate – specifically, whether it falls within the category of documentation described in section 10.6.12(B)(3) above.

10.6.14 – Application Fees

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

The contractor shall review section 10.3 of this chapter for special instructions regarding application fee and waiver submissions with PECOS applications.

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 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

i. 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: (A) 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 (B) 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).

ii. 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 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).

  (*The contractor shall begin processing the application as normal if,* at any time during this 30-day period*: (1) for paper applications,* the provider submits a Pay.gov

receipt as proof of payment*; or (2) for PECOS applications, the provider pays the fee via PECOS.)*

- 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.

iii. 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.

3. PECOS Applications

(For PECOS applications, the provider must submit any required application fee (i.e., initials, revalidations, new practice locations) or hardship waiver via PECOS at the time it submits its application; otherwise, PECOS will not accept the application. Some of the instructions in subsection (B)(2) may therefore be inapplicable to PECOS applications.)

As stated in section 10.3 of this chapter, application fees can be combined if multiple enrollment records are implicated by the submission (e.g., consolidated application), but each application still requires a separate fee. To illustrate, suppose an entity is enrolling 5 different IDTFs, and the fee amount is $631 per IDTF. The provider can submit separate $631 fees or can combine them into a $3,155 payment. In the case of hardship waivers, however, 5 separate hardship waivers – one for each enrollment – must be submitted; they cannot be combined into one waiver request.

C. Fee Amount

1. General Background

Except as stated in subsection (C)(2), the application fee must be in the amount prescribed by CMS for the calendar year (1) in which the application is submitted (for 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

a. Paper Applications - 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.

b. PECOS Applications – In a similar vein, the fee is based on the number of applications involved. Even if the provider submits one set of data into PECOS, it may involve several different applications, thus requiring separate fees. To illustrate, assume a provider exists in

Tennessee, Arkansas, and Missouri, each of which is in a separate contractor jurisdiction. As discussed in section 10.3 of this chapter, the group may submit a consolidated application (e.g., one set of data encompassing all three enrollments), which PECOS would then split into three separate applications. Three fees must be paid, however, because three separate enrollment applications are involved.

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 PECOS, the hardship exception letter must accompany the application *(i.e., the provider must upload the letter and supporting documentation into PECOS)*. Hardship exception letters shall not be considered if they were submitted separately from the application. 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, 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.

10.6.17 – Deceased Practitioners

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Reports of Death from the Social Security Administration (SSA)

Contractors, including DME MACs, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities *in this section 10.6.17.*

B. Erroneous Report of Death

In the event of an erroneous report of death, the contractor shall *contact its* PEOG BFL for guidance.

C. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners, and/or *DMEPOS* Suppliers

(If the person is an owner, sole owner of his/her professional corporation or professional association, managing employee, director, officer, authorized official, etc., the contractor shall verify and document *in PECOS* that the person is deceased using the process described in *section* 10.6.17(D)(1).)

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR § 424.540(a)(2). (*For* DMEPOS Suppliers - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR § 424.57(c)(2).) The contractor need not, however, solicit a Form CMS-855 change request if the organization is enrolled with another contractor. *Instead,* the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 10.6.17.

D. Reports of Death from Third-Parties

1. Verification of Death

If a contractor *(*including DME MACs*)* receives a report of death from a third-party (*e.g.,* state provider association, state medical society, academic medical institution, etc.), the contractor shall verify that the physician, non-physician practitioner, or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits;

- Obtaining an obituary notice from the newspaper;

- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);

- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or

- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

All verification shall be documented in PECOS per section 10.6.19(I) (and, as applicable, section 10.3) of this chapter; in addition, any documents that were used to confirm the death (e.g., obituary notice) shall be uploaded into PECOS.

2. Deceased Individuals: Post-Confirmation Actions

Once the contractor verifies the death, it shall:

a. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.

b. Search PECOS to determine whether the individual is listed therein as an owner, managing employee, director, officer, partner, authorized official, or delegated official of another supplier.

c. If the person is not in PECOS, no further action with respect to that individual is needed.

d. If the supplier is indeed identified in PECOS as an owner, sole owner of his/her professional corporation or professional association, officer, etc., the contractor shall notify the organization with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with § 424.540(a)(2). (*For* DMEPOS Suppliers - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with § 424.57(c)(2).) The contractor need not, however, ask for a Form CMS-855 change request if the organization is enrolled with another contractor. *Instead,* the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 10.6.17.

E. Deceased Individuals: Education & Outreach

Contractors *(*including DME MACs*)* shall conduct outreach to state provider associations, state medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death of physicians and non-physician practitioners participating in the Medicare program.

F. Process to Deactivate NPI Due to a Death

1. Trustees/Legal Representatives

The trustee/legal representative of a deceased physician, non-physician practitioner, or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.

2. Special Payment Address: Process to Update to an Estate Upon a Death

In situations where a physician, non-physician practitioner, or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the physician, non-physician practitioner, or DMEPOS supplier's estate to change the deceased's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.

- Any evidence – within reason - verifying that the physician, non-physician practitioner, or DMEPOS supplier is in fact deceased.

- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner, or DMEPOS supplier's estate.

The policies in this section 10.6.17(F) and (G) apply only to physicians, non-physician practitioners. and DMEPOS suppliers who operated their business as sole proprietors. It does not apply to solely-owned corporations, limited liability companies, etc., nor to situations in which the physician or non-physician practitioner reassigned his or her benefits to another entity.

All verification shall be documented in PECOS per section 10.6.19(I) of this chapter; in addition, any documents that were used to confirm the death (e.g., obituary notice) shall be uploaded into PECOS.

G. Other Enrollment Information

1. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of his/her own practice, employs another physician (the "employed physician/practitioner") to work with him/her, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole owner die or have his/her billing privileges revoked and the provider/supplier fails to submit an updated *Form* CMS-855 within 90 days, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the enrollments for both shall be deactivated in accordance with the deactivation procedures outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a professional corporation, a professional association, or a solely-owned limited liability company.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides deactivating the enrollments of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

a. The practice's billing privileges have been deactivated;

b. Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death or date of revocation or deactivation will not be paid; and

c. If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit a Form CMS-855I change of information request to add the

owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 10.6.17(G)(1)(c) only, submission of an *initial* Form CMS-855I and a terminating Form CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

H. Proof of Life Documentation

On rare occasions, erroneous death information may be received through the DMF process that results in systematic enrollment deactivations in PECOS or records populated on the Deceased Associates reports in PECOS for *contractor* deactivation actions. In order for the providers/suppliers to reactivate their enrollments and have the date of death removed from their PECOS records, *the contractor* shall request documentation that supports "proof of life" (for example, Retirement, Survivors, and Disability Insurance document issued by SSA). *If the* provider/supplier is unable to obtain such documentation, the *contractor* shall submit a request to their PEOG BFL containing the provider/supplier's name, date of birth, and SSN so that CMS can confirm proof of life with SSA.

10.6.19 – Other Medicare Contractor Duties

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

(The contractor also shall review section 10.3 of this chapter regarding the topics in this section 10.6.19. In the event of a conflict, those instructions take precedence over those in this section 10.6.19.)

The contractor shall adhere to all instructions in this chapter and other CMS provider enrollment directives (e.g., *t*echnical *d*irection *l*etters). The contractor shall also assign the appropriate number of staff to the Medicare enrollment function to ensure that all such instructions and directives - including application processing timeframes and accuracy standards - are complied with and met.

A. Training

The contractor shall provide (1) training to new employees, and (2) refresher training (as necessary) to existing employees to ensure that each employee processes enrollment applications in a timely, consistent, and accurate manner. Training shall include, at a minimum:

- An overview of the Medicare program
- A review of all applicable regulations, manual instructions, and other CMS guidance
- A review of the contractor's enrollment processes and procedures
- Training regarding *PECOS*.

For new employees, the contractor shall also:

- Provide side-by-side training with an experienced provider enrollment analyst
- Test the new employee to ensure that he or she understands Medicare enrollment policy and contractor processing procedures, including the use of PECOS

- Conduct end-of-line quality reviews for 6 months after training or until the analyst demonstrates a clear understanding of Medicare enrollment policy, contractor procedures, and the proper use of PECOS.

For existing employees, *the contractor shall perform* periodic quality reviews and refresher trainings.

B. PECOS

The contractor shall:

- Process all enrollment actions (e.g., initials, changes, revalidations, revocations, appeals, denials) through PECOS

- Deactivate or revoke the provider or supplier's Medicare billing privileges in the Multi-Carrier System or the Fiscal Intermediary Shared System only if the provider or supplier is not in PECOS; if the provider does not exist in MCS or FISS, *the contractor shall contact its PEOG BFL prior to taking action.*

- Close or delete any aged logging and tracking (L & T) records older than 120 days for which there is no associated enrollment application

- Participate in user acceptance testing for each PECOS release

- Attend scheduled PECOS training when requested

- Report PECOS validation and production processing problems through the designated tracking system for each system release

- Develop (and update as needed) a written training guide for new and current employees on the proper processing of Form CMS-855 *and Form* CMS-20134 applications, opt-out affidavits, and the appropriate entry of data into PECOS.

C. Customer Service

1. Responding to Provider Enrollment Inquiries

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's *w*eb site or automated voice response (AVR).

- Furnishing information on where to access Form CMS-855 or *Form* CMS-20134 applications (and other general enrollment information) online

- Explaining to providers/suppliers which Form CMS-855 or CMS-20134 applications should be completed.

2. Contractor's Responsiveness to Inquiries

Excluding matters pertaining to application processing (e.g., development for missing data) and appeals (e.g., appeal of revocation), the contractor is encouraged to respond to all enrollment-related provider/supplier correspondence (e.g., e-mails, letters, telephone calls) within 30 business days of receipt.

D. Contractor Outreach to Providers

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 *and Form* CMS-20134 applications.

E. Encouraging Use of Internet-based PECOS

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment Form CMS-855 or *Form* CMS-20134, the contractor shall encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:

- The CMS Web site at which information on Internet-based PECOS can be found and at which the paper applications can be accessed (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index?redirect=/MedicareProviderSupEnroll/).
- The contractor's address so that the applicant knows where to return *the paper* application.
- Any supporting documentation required for the applicant's provider/supplier type.
- Other required forms as described in sections above. Notification can be given in any manner the contractor chooses.

F. Adherence to Responsibilities Based Upon Jurisdiction - *Audit and Claims Contractors*

1. Background

For purposes of enrollment via the Form CMS-855A, there are generally two categories of contractors: audit contractors and claims contractors. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, though, they will differ. This can happen, for instance, with provider-based entities, whereby the parent provider's contractor (audit contractor) will process the provider's enrollment application and a different contractor will pay the provider's claims (claims contractor).

Should the audit and claims contractors differ, the audit contractor shall process all changes of information, including all Form CMS-588 changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims contractor. If the provider inadvertently sends a change request to the claims contractor, the latter shall return the application per *the instructions in* this chapter.

2. Process

If the audit contractor approves the Form CMS-855A transaction in question (e.g., initial enrollment), it shall:

(i) Send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in *PECOS*. Pertinent identifying information, such as the provider name, *CCN, and NPI*, shall be included in the e-mail notification. *The audit contractor need not include any supporting documentation in the e-mail because PECOS will contain any documents (e.g., approval letters from the state).*

(ii) As applicable, fax, mail, or email an encrypted copy of the submitted Form CMS-588 to the appropriate claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall access PECOS, review the enrollment record, and, as needed, update its records accordingly.

The audit contractor shall *ensure that all* original copies of Form CMS-855A paperwork and supporting documentation *(*including all Form CMS-588s*), approval letters from the state, and other written documents related to the application are uploaded in PECOS.*

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail or fax a copy of all *SOG Location approval/denial notices/*letters it receives to the claims contractor. This is to ensure that the claims contractor is fully aware of the *SOG Location's* action, as some may only send copies of the approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

*I*t is imperative that audit and claims contractors effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

G. Online Presence – Web Sites

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/index.html?redirect=/medicareprovidersupenroll/ . The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2) comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194 and with CMS' Contractor Website Standards and Guidelines posted on CMS's *w*eb site.

The CMS Provider/Supplier Enrollment Web site *gives* users access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment *w*ebsite and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its *w*ebsite that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis (specifically, no later than the 15th day of January, April, July, and October), each contractor shall review and provide updates regarding its contact information

shown at URL: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf. If the contractor services several *s*tates with a universal address and telephone number, the contractor shall report that information. In situations where no *updates* are *needed*, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's PEOG BFL.

H. Document *Uploading and* Retention

1. Introduction

To ensure that proper internal controls are maintained and that important information is recorded in case of potential litigation, the contractor shall maintain documentation as outlined in this section 10.6.19(H) and, as applicable, section 10.3. CMS cannot stress enough how crucial it is for contractors to document their actions as carefully and thoroughly as possible.

The requirements in this section 10.6.19(H) are in addition to, and not in lieu of, all other documentation or document maintenance requirements that CMS has mandated.

The contractor shall maintain and store all documents relating to the enrollment of a provider into Medicare. These documents include, but are not limited to, Medicare enrollment applications and all supporting documents, attachments, correspondence, and correspondence tracking documentation, and appeals submitted in conjunction with an initial enrollment, reassignment, change of enrollment, revalidation, etc.

Supporting documentation includes, but is not limited to:

- Copies of *f*ederal, *s*tate and/or local (city/county) professional licenses, certifications and/or registrations;
- Copies of *f*ederal, *s*tate, and/or local (city/county) business licenses, certifications and/or registrations;
- Copies of professional school degrees or certificates or evidence of qualifying course work;
- Copies of CLIA certificates and FDA mammography certificates;
- Copies of any entry found on the *MED* report that leads to a provider or supplier's revocation, and;
- Copies of Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) recognition letters or certificates indicating *f*ull or MDPP preliminary recognition.

See section 10.6.19(I) below for additional document uploading requirements.

2. Document Disposal

The contractor shall dispose of the aforementioned records as described below:

i. **Provider/Supplier and Durable Medical Equipment Supplier Application**

a. Rejected applications as a result of provider failing to provide additional information

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

Disposition: Destroy 15 years after the provider/supplier's enrollment has ended.

c. Denied applications of provider/supplier

Disposition: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but the billing number was subsequently revoked

Disposition: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

ii. **Electronic Mail and Word Processing System Copies**

a. Copies that have no further administrative value after the recordkeeping copy is made. These include copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

Disposition: Delete within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy.

Disposition: Delete when dissemination, revision, or updating is complete.

I. Keeping Record of Activities

As with document retention as described in subsection (H) above, it is important that the contractor maintains records of its written and telephonic communications. The contractor shall thus adhere to the instructions in this subsection (I).

1. Written Communications

(For purposes of this section 10.6.19*(I)(1),* "written correspondence" includes mailed, faxed, and e-mailed correspondence*. Note that this is different from supporting documentation accompanying an enrollment application, the requirements for which are addressed in subsection (H) above.)*

*Except as stated in this subsection (I)(1), t*he contractor shall:

- Retain copies of all written correspondence pertaining to the provider, regardless of whether the correspondence was initiated by the contractor, the provider, CMS, *s*tate officials, etc.

- Document when it sends written correspondence to providers. For instance, if the contractor crafts an approval letter to the supplier dated March 1 but sends it out on March 3, the contractor shall note this in *PECOS.*

- Document all referrals to CMS, the UPIC, or the OIG

In cases where the written correspondence is sent directly via or to PECOS (e.g., PCV), the contractor need not separately document this; PECOS will retain this information (date, time, etc.). For all other written correspondence not sent via or to PECOS, the contractor (1) shall upload a copy of the correspondence into PECOS (e.g., fax, a printed copy of the e-mail) and (2) shall note in PECOS:

- *The type of correspondence (e.g., approval letter)*
- *The form of correspondence (e.g., fax, e-mail)*
- *The date and time the correspondence was sent*
- *The party to whom the correspondence was sent (e.g. provider name, contact person)*

2. Telephonic or Face-to-Face Contact

(Telephonic or face-to-face contact is hereafter referred to as "oral communication.")

The contractor shall document any and all actual or attempted oral communication with the provider, any representative thereof, or any other person or entity regarding a provider. This includes, but is not limited to, the following situations:

- Telephoning a provider about its application. (Even if the provider official was unavailable and a voice mail message was left, this must be documented.)

- Requesting information from the state or another contractor concerning the applicant or enrollee

- Contacting the UPIC for an update concerning a particular case

- Phone calls from the provider

- Conducting a meeting at the contractor's headquarters/offices with officials from a hospital concerning problems with its application

- Telephoning PEOG, the *state agency, or the SOG Location* and receiving instructions therefrom about a problem the contractor is having with an applicant or an existing provider

- Telephoning the provider's billing department with a question about the provider.

When documenting oral communications, the contractor shall indicate (1) the time and date of the call or contact, (2) who initiated the contact, (3) who was spoken with, and (4) what the conversation pertained to. Concerning the last requirement, the contractor need not write down every word that was said during the conversation. Rather, the documentation should merely be adequate to reflect the contents of the conversation.

The documentation requirements in this *subsection (I)(2)* only apply to enrolled providers and to providers that have already submitted an enrollment application. In other words, these documentation requirements go into effect only after the provider submits an initial application. To illustrate, if a hospital contacts the contractor requesting information concerning how it should enroll in the Medicare program, this need not be documented because the hospital has not yet submitted an enrollment application.

All oral communications addressed in this subsection (I)(2) shall be documented in PECOS.

If an application is returned, the contractor shall document this. The manner of documentation lies within the contractor's discretion.

J. Documenting Verification of Data Elements

Once the contractor has completed its review of the *Form* CMS-855 *and Form* CMS-20134 applications (e.g., approved/denied application, approved change request) *as well as o*pt-out *a*ffidavits, it shall document that it has: (1) verified all data elements on the application, and (2) reviewed all applicable names on the above- mentioned forms against the OIG/LEIE and the System for Access Management (SAM). It can be drafted in any manner the contractor chooses so long as it certifies that the above-mentioned activities were completed.

For each person or entity that appeared on the OIG/LEIE or SAM, the contractor shall document *any positive* findings via a screen printout *and upload it into PECOS*. In all other situations, the contractor is not encouraged to document their reviews via screen printouts. Simply using the verification statement described above is sufficient. Although the contractor has the discretion to use screen prints if it so chooses, the *aforementioned* verification statement is still required.

K. Release of Information

On October 13, 2006, CMS published System of Records Notice for *PECOS* in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s), delegated official(s), or contact persons. The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.
- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized; and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or e-mailed to the contractor. *The contractor shall upload the letter in PECOS.*
- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 or CMS-20134 paperwork the contractor has on file *that the provider does not already*

have access to in PECOS. For instance, if the provider already uses PECOS for application submissions, the contractor can simply refer the provider to PECOS if the document in question is in PECOS. If the provider does not use PECOS, the contractor shall not require the provider to do so in order to access the document(s) but shall follow the above instructions; the latter shall also be followed if the provider uses PECOS but the requested document is not in PECOS.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

The following information shall be made available over-the-phone to a caller who is able to provide a provider/supplier's name, PTAN, TIN/SSN, and NPI number*; t*he caller *need* not be listed on the provider/supplier's enrollment record as a contact person:

- Revalidation status (i.e., whether or not a provider/supplier has been revalidated)
- Revalidation due date
- Revalidation approval date
- The specific information related to a revalidation development request
- The date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as *SSNs or EINs*, without first encrypting the email.
- The contractor may not send PECOS screen printouts to the provider.
- With the exception of *Form* CMS-855S applications, if any contact person listed on *the* provider*'s* enrollment record requests a copy of a provider*'s* Medicare approval letter or revalidation notice *and the contact person does not have access to PECOS*, the contractor shall send to the contact person via email, fax or mail. (This excludes *c*ertification Letters *from the state agency*, *for* the contractor *does not* generat*e* these approvals.) *If the contact person has access to PECOS, the contractor can simply refer him/her to PECOS. If the contact person does not use PECOS, the contractor shall not require the contact person to do so in order to access the document(s) but shall follow the above instructions; the latter shall also be followed if the contact person uses PECOS but the requested document is not in PECOS.)*

L. Security

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. *Also,* provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users,

system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks, and information.

Note that these instructions are in addition to, and not in lieu of, all other *CMS* instructions regarding security.

M. Establishment of Relationships

To the maximum extent possible, and to help ensure it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate *s*tate government entities – such as, but not limited to, Medicaid fraud units, *s*tate licensing boards, and criminal divisions –to facilitate the flow of felony information from the *s*tate to the contractor. For instance, the contractor can request that the *s*tate inform it of any new felony convictions of health care practitioners.

N. Monitoring Information from State Licensing Boards

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below. (For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.)

No later than the 15th day of each month, the contractor shall review *s*tate licensing board information for each *s*tate within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

- Had *his/her* medical license revoked, suspended, or inactivated (due to retirement, death, or voluntary surrender of license);

- Otherwise lost *his/her* medical license or have had *his/her* license expire.

For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps pursuant to this chapter.

The mechanism by which the contractor perform*s* these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

O. Regarding Potential Identity Theft or Other Fraudulent Activity

If --when conducting the verification activities described in this chapter -- the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor shall notify its *PEOG BFL* immediately; the BFL will instruct the contractor as to what, if any, action shall be taken *(For example, a physician indicates that she is not establishing a new practice location or changing her EFT information, and that the application submitted in his/her name is false.)*

10.6.20 – Screening: On-site Inspections and Site Verifications

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

The contractor shall review section 10.3 of this chapter for special instructions regarding site visits. In the event of a conflict, those instructions take precedence over those in this section 10.6.20.

A. DMEPOS Suppliers and IDTFs

The scope of site visits of DMEPOS suppliers and IDTFs shall continue to be conducted in accordance with existing CMS instructions and guidance.

(For purposes of this section 10.6.20, the term "contractor" refers to the Medicare Administrative Contractor; the term "SVC" refers to the site visit contractor.)

B. Provider and Supplier Types *Other Than DMEPOS Suppliers and IDTFs*

For *provider/*supplier types other than DMEPOS suppliers and IDTFs – that must undergo a site visit pursuant to this section 10.6.20 and § 424.518, the SVC will perform such visits consistent with the procedures in this section 10.6.20. This includes *all of* the following:

(1) Documenting the date and time of the visit, and including the name of the individual attempting the visit.

(2) Photographing the provider/supplier's business for inclusion in the provider/supplier's file. All photographs will be date/time stamped.

(3) Fully documenting observations made at the facility, which could include facts such as (a) the facility was vacant and free of all furniture, (b) a notice of eviction or similar documentation is posted at the facility, and (c) the space is now occupied by another company.

(4) Writing a report of the findings regarding each site verification.

(5) Including a signed site visit report stating the facts and verifying the completion of the site verification.

In terms of the extent of the visit, the SVC will determine whether the following criteria are met: (i) the facility is open; (ii) personnel are at the facility; (iii) customers are at the facility (if applicable to that provider or supplier type); and (iv) the facility appears to be operational. This will require the site visitor(s) to enter the provider/supplier's practice location/site rather than simply conducting an external review. If any of the four elements ((i) through (iv)) listed above are not met, the contractor will, as applicable - and using the procedures outlined in this chapter and in existing CMS instructions - deny the provider's enrollment application pursuant to § 424.530(a)(5)(i) or (ii) or revoke the provider's Medicare billing privileges under § 424.535(a)(5)(i) or (ii).

C. Operational Status

When conducting a site verification to determine whether a practice location is operational, the SVC shall make every effort to limit its verification to an external review of the location. If the SVC cannot determine whether the location is operational based on this external review, it shall conduct an unobtrusive site verification by limiting its encounter with provider or supplier personnel or medical patients.

The contractor must review and evaluate the site visit results received from the SVC prior to making a final determination. If it is determined (during the review and evaluation process) that the location is non-operational based on the site visit results but there is reason to proceed with the enrollment, the contractor shall provide the appropriate justification in the comment section of the Validation Checklist in PECOS. (For example, a second site visit determined the location to be operational; the provider only renders services in patient's homes; etc.).

If the contractor is unsure of how to proceed based on its evaluation of the site visit results, it shall contact its *PEOG BFL* and copy its contracting officer's representative (COR).

D. Timing

Site verifications should be done Monday through Friday (excluding holidays) during their posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m. If, during the first attempt, there are obvious signs that the facility is no longer operational, no second attempt is required. If, on the first attempt, the facility is closed but there are no obvious indications that the facility is non-operational, a second attempt on a different day during the posted hours of operation should be made.

E. Documentation

As indicated previously, when conducting site verifications to determine whether a practice location is operational, the SVC shall:

(i) Document the date and time of the attempted visit and include the name of the individual attempting the visit.

(ii) As appropriate, photograph the provider/supplier's business for inclusion in the provider/supplier's file on an as-needed basis. All photographs should be date/time stamped.

(iii) Fully document all observations made at the facility (e.g., the facility was vacant and free of all furniture, a notice of eviction or similar documentation was posted at the facility, the space is now occupied by another company, etc.).

(iv) Write a report of its findings regarding each site verification.

F. Determination

(In the event an instruction in this subsection F is inconsistent with guidance in section 10.6.6, 10.4.7 et seq., or 10.4.8, the latter three sections of instructions shall take precedence.)

If a provider/supplier is determined not to be operational or in compliance with the regulatory requirements for its provider/supplier type, the contractor shall revoke the provider/supplier's Medicare billing privileges - unless the provider/supplier has submitted a change of information request that notified the contractor of a change in practice location. Within 7 calendar days of CMS or the contractor determining that the provider/supplier is not operational, the contractor shall update PECOS or the applicable claims processing system (if the provider/supplier does not have an enrollment record in PECOS) to revoke Medicare billing privileges and issue a revocation notice to the provider/supplier. The contractor shall afford the provider/supplier applicable appeal rights in the revocation notification letter.

For non-operational status revocations, the contractor shall use either 42 CFR § 424.535(a)(5)(i) or 42 CFR § 424.535(a)(5)(ii) as the legal basis for revocation. Consistent with 42 CFR § 424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider/supplier is no longer operational. The contractor shall establish a 2-year reenrollment bar for providers/suppliers that are not operational.

For regulatory non-compliance revocations, the contractor shall use 42 CFR § 424.535(a)(1) as the legal basis for revocation. Consistent with 42 CFR § 424.535(g), the date of revocation is the date on which CMS or the contractor determines that the provider/supplier is no longer in compliance with regulatory provisions for its provider/supplier type. The

contractor shall establish a 2-year enrollment bar for providers/suppliers that are not in compliance with provisions for their provider/supplier type.

G. Multiple Site Visits

Notwithstanding any other instruction to the contrary in this chapter, the contractor shall not order a site visit if the specific location to be visited has already undergone a successful site visit within the last 12 months and the applicable provider/supplier is in an approved status.

Consider the following illustrations:

Example 1 - A single-site home health agency (HHA) undergoes a revalidation site visit on February 1. The HHA submits a change of information request on July 1 to add a branch location. The contractor shall order this site visit because the visit will occur at a location (i.e., the branch location) different from the main location (i.e., the location that underwent the February 1 revalidation visit).

Example 2 - A DMEPOS supplier undergoes a revalidation site visit on April 1. It submits an initial Form CMS-855S application on May 1 to enroll a second location. The new location shall undergo a site visit because: (1) it is different from the first (revalidated) location; and (2) it is/will be separately enrolled from the first location.

Example 3 - A physical therapy (PT) group has three locations – X, Y, and Z. As part of a revalidation, the contractor elects to order a site visit of Location Y rather than X or Z. The visit was performed on June 1. On October 4, the group submits a Form CMS-855B to report a change of ownership, thus requiring a site visit under this chapter. However, the contractor shall not order a visit for Location Y because this site has been visited within the past 12 months. Location X or Location Z must instead be visited.

Example 4 - An IDTF undergoes an initial enrollment site visit on July 1. On September 24, it submits a Form CMS-855B application to change its practice location; this mandates a site visit under this chapter. The site visit shall be performed even though the initial visit took place within the past 12 months. This is because the second visit will be of the new location, whereas the first visit was of the old location.

H. Certified Providers/Suppliers – Address Validation Error

Notwithstanding any other instruction to the contrary in this chapter, the contractor need not order a site visit for a certified provider/supplier prior to making a recommendation to the state if an address validation error is received in PECOS. The contractor shall override the error message and notate in the referral package that the address was unverifiable. This avoids multiple site visits being performed (that is, pre-enrollment, survey, and post enrollment).

10.7 – Model Letters

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

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.

As stated in section 10.3, PECOS will automatically generate and send some of the letters described in this section 10.7 et seq. If any modifications or additions to a certain PECOS-

generated letter are required pursuant to the instructions in this section 10.7 et seq. or elsewhere in this chapter, the contractor shall, of course, ensure that such edits are made before the letter is sent. This includes situations where a particular party is typically copied on a letter but the circumstances of the transaction do not require the party to be copied.

In the event of a conflict between the instructions in section 10.3 and section 10.7, et al, the instructions in section 10.3 take precedence.

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 state 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 tie-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). However, 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 contractor 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 change of information 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 contractor shall add appeal rights to all change of information and revalidation 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 non-certified 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 contractor 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.

(e) This subsection (A)(3)(e) applies to certified provider and certified supplier denial or revocation letters that meet both of the following requirements:

- The provider enrollment denial or revocation also requires the denial or termination of the corresponding provider or supplier agreement (e.g., Form CMS-1561, Form CMS-370, etc.)
- The SOG Location is responsible for handling the reconsideration/appeal of the provider/supplier agreement denial or termination.

If these requirements are met -- and notwithstanding any instruction to the contrary in this chapter -- the contractor shall insert the following language into the provider enrollment denial or revocation letter (preferably at the conclusion of the letter's discussion/outline of appeal rights):

"Note that the provider enrollment appeal rights addressed in this letter are unrelated to any appeal rights concerning the [denial or termination, as applicable] of your [provider or supplier, as applicable] agreement. The two processes are separate and distinct, and a successful appeal of your enrollment [denial or revocation, as applicable] does not automatically restore your [provider or supplier] agreement. Any such restoration of the latter is handled by the Survey Operations Group Location and not by CMS' Provider Enrollment & Oversight Group."

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 n umber 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 revalidations in which multiple PTANs may be revalidating from multiple reassignments or individual associations, the contractor may also list the group's LBN and PTAN effective date in connection with the appropriate individual NPI-PTAN combinations. The contractor 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. Otherwise, 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 contractor 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. As applicable, the contractor shall continue to send letters to the DMEPOS 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. However, 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.

8. Notwithstanding any other instruction to the contrary in this chapter, the contractor shall copy via email the applicable accrediting organization (AO) (along with, as currently required, the state agency) on a recommendation for approval letter or final provider/supplier notification letter (e.g., final approval, denial, etc.) letter if: (1) the provider/supplier lists the AO on the Form CMS-855 or ADR application; (2) PEOG notifies the contractor of the AO's involvement; or (3) the contractor otherwise becomes aware of the provider/supplier's AO affiliation.

10.7.2 – Development Letters

(Rev. 11949; Issued: 04-13-23; Effective: 04-21-23; Implementation: 06-19-23)

A. Development Letter Guidance

In the following sentence:

"Please submit the requested revisions and/or supporting documentation preferably within [xx] calendar days of the postmarked date of this letter to the address listed below:"

The value in "xx" may be from **7** to **30**.

Note: Items such as checklists and documents may be attached to the letter.

B. Model Development Letters

Example

[month] [day], [year]

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

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

Dear [Provider/Supplier Name]:

We have received your Medicare enrollment application(s). We may reject your application(s) if you do not furnish complete information within 30 calendar days from the postmarked date of this letter pursuant to 42 CFR §424.525. In order to complete processing

your application(s), please make the following revisions and/or supply the requested supporting documentation:

[Specify revisions and/or supporting documentation needed]

[If the application was submitted via paper, use the following language:

"Please submit the requested revisions and/or supporting documentation within [xx] days of the postmarked date of this letter to the address listed below:

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

Finally, please attach a copy of this letter with your revised application(s)."]

[If the application was submitted via PECOS, use the following language:

"Please submit the requested revisions and/or supporting documentation via PECOS within [xx] days of the date on this 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,

[Name]
[Title]
[Company]