

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12393	Date: December 7, 2023
	Change Request 13333

SUBJECT: Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08 - Home Health Prospective Payment System (HH PPS) Final Rule

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of CMS Pub. 100-08 with instructions regarding the implementation of certain provider enrollment regulatory provisions in the Calendar Year (CY) 2024 HH PPS final rule.

EFFECTIVE DATE: January 1, 2024

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

IMPLEMENTATION DATE: January 2, 2024

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/Table of Contents
R	10/10.1/10.1.1/Definitions
R	10/10.2/10.2.1.6/Home Health Agencies (HHAs)
R	10/10.2/10.2.1.6.1/Reserved for Future Use
R	10/10.4/10.4.8/Deactivations
R	10/10.4/10.4.8.1/Deactivation Rebuttals
R	10/10.6/10.6.1.1/Changes of Ownership (CHOWs) – Transitioned Certified Providers and Suppliers
N	10/10.6/10.6.1.1.5/HHA and Hospice Ownership Changes
R	10/10.6/10.6.7.2/Individual Owning and Managing Information
R	10/10.6/10.6.15/Risk-Based Screening
R	10/10.7.5/10.7.5.1/Part A/B Certified Provider and Supplier Letter Templates – Post-Transition
R	10/10.7/10.7.12/Deactivation Model Letter

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: 12393	Date: December 7, 2023	Change Request: 13333
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IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The CY 2024 HH PPS final rule (88 Federal Register 77676) contains provisions concerning Medicare provider enrollment. These include, but are not limited to: (1) Expanding the home health agency "36-month rule" to include hospice changes in majority ownership; and (2) Moving hospices into the "high" level of categorical risk-screening. Except for the provisions concerning prohibitions against ordering, certifying, etc. (which CMS will address in separate guidance to the contractors), this CR will update Chapter 10 of CMS Pub. 100-08 with instructions regarding these regulatory provisions.

B. Policy: CY 2024 HH PPS final rule.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
13333.1	The contractor shall observe the clarification of the definition of "managing employee" in Section 10.1.1 in Chapter 10 of CMS Pub. 100-08.	X		X						
13333.2	The contractor shall observe the regulatory change in 42 Code of Federal Regulations (CFR) § 424.540(a)(1) reducing the	X	X	X						NPEAS T, NPWES T

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	period of non-billing from 12 months to 6 months. (This reduction does not otherwise change existing operational procedures for deactivating providers/suppliers under § 424.540(a)(1).)									
13333.3	The contractor shall apply to hospices the 36-month rule change in majority ownership policies in Section 10.6.1.1.5 in Chapter 10 of CMS Pub. 100-08.	X		X						
13333.4	The contractor shall, as applicable to the enrollment transaction in question, screen hospice enrollment applications at the "high" level of categorical screening in the circumstances described in Section 10.6.15 in Chapter 10 of CMS Pub. 100-08.	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
13333.5	The contractor shall screen enrollment applications for which fingerprinting had been waived consistent with the instructions in Section 10.6.15(A)(5) in Chapter 10 of Pub. 100-08.	X	X	X						NPEAST, NPWEST

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13333.6	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

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

V. CONTACTS

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

Table of Contents
(Rev. 12393; Issued: 12-07-23)

Transmittals for Chapter 10

10.2.1.6.1 – Reserved for Future Use

10.6.1.1.5 – HHA and Hospice Ownership Changes

10.1.1 – Definitions

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

Below is a list of terms commonly used in the Medicare enrollment process:

Accredited provider/supplier means a supplier that has been accredited by a CMS-designated accreditation organization.

Add – For purposes of completing the Form CMS-855 or Form CMS-20134 enrollment applications, you are adding enrollment information to your existing enrollment record (e.g., practice locations). When adding a practice location, an application fee may be required for applicable institutions. (For further information, see the term “institutional provider” as defined in 42 CFR § 424.502, the application fee requirements in 42 CFR § 424.514, and the application fee guidance in section 10.6.14 of this chapter.)

Administrative location means a physical location associated with a Medicare Diabetes Prevention Program (MDPP) supplier’s operations from where: (1) coaches are dispatched or based; and (2) MDPP services may or may not be furnished.

Advanced diagnostic imaging service means any of the following diagnostic services:

- (i) Magnetic Resonance Imaging (MRI)
- (ii) Computed Tomography (CT)
- (iii) Nuclear Medicine
- (iv) Positron Emission Tomography (PET)

Applicant means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to: (1) receive a Medicare billing number and be granted Medicare billing privileges; or (2) enroll to solely order, certify, or refer the items or services described in 42 CFR § 424.507.

Authorized official (as defined by 42 CFR § 424.502) means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Billing agency means an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services. In order to receive payment directly from Medicare on behalf of a provider or supplier, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act. (For further information, see CMS Publication (Pub.) 100-04, Claims Processing Manual, chapter 1, section 30.2.4.)

Change - For purposes of completing the Form CMS-855 or CMS-20134 enrollment applications, you are replacing existing information with new information (e.g. practice location, ownership) or updating existing information (e.g. change in suite #, telephone #). If you are changing a practice location an application fee is not required.

Change in majority ownership occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a home health agency (HHA) *or hospice* during the 36 months following the HHA's *or hospice's* initial enrollment into the Medicare program or the 36 months following the HHA's *or hospice's* most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA *or hospice* through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's or *hospice's* most recent change in majority ownership. (See 42 CFR § 424.550(b) for more information on HHA *and hospice* changes of ownership.)

Change of ownership (CHOW) is defined in 42 CFR § 489.18(a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions/deeming activities specified. (See 42 CFR §§ 488.1 and 488.5 for more information on accrediting organizations.)

Coach means an individual who furnishes MDPP services on behalf of an MDPP supplier as an employee, contractor, or volunteer.

Community setting means a location where the MDPP supplier furnishes MDPP services outside of its administrative locations in meeting locations open to the public. A community setting is a location not primarily associated with the supplier where many activities occur, including, but not limited to, MDPP services. Community settings may include, for example, church basements or multipurpose rooms in recreation centers.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated official (as defined by 42 CFR § 424.502) means an individual who is delegated by the "Authorized Official" the authority to report changes and updates to the provider/supplier's enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.

Delete/Remove – For purposes of completing the Form CMS-855 enrollment and Form CMS-20134 applications, you are removing existing enrollment information. If you are deleting or removing a practice location, an application fee is not required.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to: (1) receive Medicare billing privileges; or (2) enroll to solely order, certify, or refer the items or services described in 42 CFR § 424.507.

Director means a director of a corporation, regardless of whether the provider or supplier is a non-profit entity. This includes any member of the corporation's governing body irrespective of the precise title of either the board or the member; said body could be a board of directors, board of trustees, or similar body.

Effective Date means the date on which a provider's or supplier's eligibility was initially established for the purposes of submitting claims for Medicare-covered items and services and/or ordering or certifying Medicare-covered items and services. (This is not the same as a reactivation effective date.)

Eligible coach means an individual who CMS has screened and determined can provide MDPP services on behalf of an MDPP supplier.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services.

Enrollment application means a paper Form CMS-855 or Form CMS-20134 enrollment application or the equivalent electronic enrollment process approved by the Office of Management and Budget (OMB).

Final adverse legal action means the following:

For purposes of the definition of this term in § 424.502, final adverse action means one or more of the following:

- (1) A Medicare-imposed revocation of any Medicare billing privileges;
- (2) Suspension or revocation of a license to provide health care by any state licensing authority;
- (3) Revocation or suspension by an accreditation organization;
- (4) A conviction of a federal or state felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
- (5) An exclusion or debarment from participation in a federal or state health care program.

For purposes of the reporting requirements on the Form CMS-855 or Form CMS-20134, final adverse action means one or more of the following:

Convictions (as defined in 42 CFR 1001.2) within the preceding 10 years

1. Any federal or state felony conviction(s).
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any current or past revocation, suspension, or voluntary surrender of a medical license in lieu of further disciplinary action.

2. Any current or past revocation or suspension of accreditation.
3. Any current or past suspension or exclusion imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG).
4. Any current or past debarment from participation in any Federal Executive Branch procurement or non- procurement program.
5. Any other current or past federal sanctions.
6. Any Medicaid exclusion, revocation, or termination of any billing number.

Immediate family member or member of a physician's immediate family means – under 42 CFR § 411.351 - a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Ineligible coach means an individual whom CMS has screened and determined cannot provide MDPP services on behalf of an MDPP supplier.

Institutional provider means – for purposes of the Medicare application fee only - 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.

Legal business name is the name that is reported to the Internal Revenue Service (IRS).

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier. *For purposes of this definition of managing employee, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.*

Managing organization means an entity that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the provider or supplier, either under contract or through some other arrangement.

Medicare identification number - For Part A providers, the Medicare identification number is the CMS Certification Number (CCN). For Part B suppliers the Medicare identification number is the Provider Transaction Access Number (PTAN).

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).

Officer means an officer of a corporation, regardless of whether the provider or supplier is a non-profit entity.

Operational – under 42 CFR § 424.502 – means that the provider or supplier has a qualified physical practice location; is open to the public for the purpose of providing health care related services; is prepared to submit valid Medicare claims; and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Other eligible professional – as defined in 1848(k)(3)(B) of the Social Security Act – means: (i) a physician; (ii) a practitioner described in section 1842(b)(18)(C); (iii) a physical or occupational therapist or a qualified speech-language pathologist; or (iv) a qualified audiologist (as defined in section 1861(l)(3)(B)). (For (ii), “practitioner” is defined in section 1842(b)(18)(C) as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or registered dietitian or nutrition professional.)

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124(A) of the Social Security Act.

Ownership or investment interest – under 42 CFR § 411.354(b) – means an ownership or investment interest in the entity that may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in any entity that furnishes designated health services.

Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Social Security Act.

Physician-owned hospital – under 42 CFR § 489.3 – means any participating hospital in which a physician, or an immediate family member of a physician, has a direct or indirect ownership or investment interest, regardless of the percentage of that interest.

Physician owner or investor – under 42 CFR § 411.362(a) – means a physician (or an immediate family member) with a direct or an indirect ownership or investment interest in the hospital.

Prospective provider means any entity specified in the definition of “provider” in 42 CFR § 498.2 that seeks to be approved for coverage of its services by Medicare.

Prospective supplier means any entity specified in the definition of “supplier” in 42 CFR § 405.802 that seeks to be approved for coverage of its services under Medicare.

Provider is defined at 42 CFR § 400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Reassignment means that an individual physician, non-physician practitioner, or other supplier has granted a Medicare-enrolled provider or supplier the right to receive payment for the physician’s, non-physician practitioner’s or other supplier’s services. (For further information, see § 1842(b)(6) of the Social Security Act, the Medicare regulations at 42 CFR §§424.70 - 424.90, and CMS Pub. 100-04, chapter 1, sections 30.2 – 30.2.16.)

Reject/Rejected means that the provider or supplier’s enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner. (See 42 CFR § 424.525 for more information.)

Retrospective Billing Privileges means that certain Part B suppliers can bill retrospectively for up to 30 or 90 days prior to their enrollment effective date as described in 42 CFR §§ 424.520(d) and 424.521(a).

Revoke/Revocation means that the provider's or supplier's billing privileges are terminated.

Supplier is defined in 42 CFR § 400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Tax identification number means the number (either the Social Security Number (SSN) or Employer Identification Number (EIN) that the individual or organization uses to report tax information to the IRS.

10.2.1.6 - Home Health Agencies (HHAs)

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Background

1. General Information

An HHA is an entity that provides skilled nursing services and at least one of the following therapeutic services: speech therapy, physical therapy, occupational therapy, home health aide services, and medical social services. The services must be furnished in a place of residence used as the patient's home.

Like most certified providers, HHAs receive a state survey (or a survey from an approved accrediting organization) to determine compliance with federal, state, and local laws) and must sign a provider agreement.

There are two potential "components" of an HHA organization:

Parent – The parent HHA is the entity that maintains overall administrative control of its location(s).

Branch – A branch office is a location or site from which an HHA provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the HHA and is located sufficiently close to the parent agency so that it shares administration, supervision, and services with the parent agency on a daily basis. The branch office is not required to independently meet the conditions of participation as an HHA; the branch can thus be listed as practice locations on the main provider's Form CMS-855A. Though the branch receives a 10-digit CCN identifier, it bills under the parent HHA's CCN.

See Pub. 100-07, chapter 2 for more information on branches.

2. Out-of-State HHA Operations

Pub. 100-07, chapter 2, section 2184 states that when an HHA provides services across state lines:

- It must be certified by the state in which its CCN is based.
- The involved states must have a written reciprocal agreement permitting the HHA to provide services in this manner. In those states that have a reciprocal agreement, HHAs are not required to be separately approved in each state; consequently, they would not have to obtain a separate Medicare provider agreement/number in each state. HHAs

residing in a state that does not have a written reciprocal survey agreement with a contiguous state are precluded from providing services across state lines; the HHA must establish a separate parent agency in the state in which it wishes to provide services.

- A CMS approved branch office may be physically located in a neighboring state if the state agencies responsible for certification in each state approve the operation.

See section 10.3.1(A)(1)(d)(iii) of this chapter for additional information regarding the enrollment of out-of-state HHA locations.

B. Processing Instructions for HHA Initial Form CMS-855A Applications

1. Receipt of Application

Upon receipt of an HHA initial Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(A) Perform all data validations otherwise required per this chapter

(B) Ensure that the application(s) is complete consistent with the instructions in this chapter

(C) Ensure that the HHA has submitted all documentation otherwise required per this chapter. For HHA initial enrollment, this also includes the following:

- Form CMS-1561 (Health Insurance Benefit Agreement, also known as a “provider agreement”)
- 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.)

(The HHA must complete, sign, date, and include the Form CMS-1561, though the HHA need not complete those sections of the form reserved for CMS. For organizational HHAs, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign.)

Notwithstanding the foregoing, if the Form CMS-1561 or the Form HHS-690 evidence 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.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.6(B) prohibits the contractor from returning or rejecting the HHA application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter’s procedures for doing so.)

(A) Approval Recommendation

If, consistent with the instructions in section 10.2.1.6(B) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the

recommendation to the state pursuant to existing practice and this chapter's instructions. The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor's recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the HHA, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter's assistance with a particular state inquiry.

(B) Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in section 10.7.8 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

(A) Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof. (The contractor may accept any notification that is in writing (e-mail is fine).) A site visit need not be performed. No later than 5 business days after receiving this notification, therefore, the contractor shall commence the actions described in section 10.2.1.6(B)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically (though not always) do so via a Form CMS-1539; the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.) No later than 5 business days after receiving the state's recommendation, the contractor shall commence the following activities:

- (i) Order a site visit
- (ii) Undertake the 3rd capitalization review discussed in section 10.6.1.2.2 of this chapter.

(iii) Ensure that each entity and individual listed in Sections 2, 5 and 6 of the HHA's Form CMS-855A application is again reviewed against the Medicare Exclusion Database (MED) and the System for Award Management (SAM). (This activity applies: (1) regardless of whether the HHA is provider-based or freestanding; and (2) only to initial enrollments.)

If:

a. The HHA is still in compliance (e.g., no owners or managing employees are excluded/debarred; capitalization is met; site visit is passed): No later than 3 business days after all of these activities are complete (i.e., the 3-day period begins when the last of the

three activities has been completed), the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- The Form CMS-855 application (or PECOS Application Data Report) and all applicable documents
- A copy of the Form CMS-1539 or similar documentation received from the state
- A copy of the provider-signed Form CMS-1561
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)

PEOG will countersign the provider agreement. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the applicable data into ASPEN, and (4) approve (with possible edits) the approval letter.

Within 5 business days of receiving from PEOG the signed provider agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned provider agreement to the HHA; (2) send a copy of both the approval letter and the provider agreement to the state and/or AO (as applicable)); and (3) switch the PECOS record from “approval recommended” to “approved” consistent with existing instructions.

b. The HHA is not in compliance (e.g., the HHA does not meet one of the requirements): The contractor shall deny the application in accordance with the instructions in this chapter.

C. Site Visits

1. Initial application –The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

2. Revalidation – If an HHA submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

3. New/changed location - If an HHA is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS no later than 5 business days after the contractor receives the approval recommendation from the state but before the contractor sends to PEOG the applicable e-mail described in section 10.6.1.2(A)(3) of this chapter. (See the latter section for more information.) This is to ensure that the new/changed location complies with CMS’s enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

D. Nursing Registries

If the HHA checks “Yes” in Section 12B of the Form CMS-855A, the contractor shall ensure that the information furnished about the HHA nursing registry is accurate. (A nursing

registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

E. Recommendation before New HHA Location Established

If an HHA is adding a branch or changing the location of its main location or an existing branch, the contractor may make a recommendation for approval to the state prior to the establishment of the new/changed location (notwithstanding any other instruction in this chapter to the contrary). If the contractor opts to make such a recommendation prior to the establishment of the new/changed location, it shall note in its recommendation letter that the HHA location has not yet moved or been established.

F. CHOWs and Changes of Information

HHA changes of ownership shall be processed in accordance with, as applicable, section *10.6.1.1.5* or section 10.6.1.1. HHA changes of information shall be processed in accordance with section 10.6.1.2.

G. Additional Information

For more information on HHAs, refer to:

- Sections 1861(o) and 1891 of the Social Security Act
- 42 CFR Part 484
- 42 CFR § 489.28 (capitalization)
- Pub. 100-07, chapter 2
- Pub. 100-04, chapter 10
- Pub. 100-02, chapter 7

10.2.1.6.1 – *Reserved for Future Use*

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

10.4.8 – Deactivations

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Bases for Contractor Action

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

- (i) The provider/supplier fails to respond to a revalidation request.
- (ii) The provider/supplier fails to respond timely to a revalidation development request.
- (iii) The provider/supplier is enrolled in an approved status with neither an active reassignment nor practice location for 90 days or longer. (The deactivation basis shall be 42 CFR § 424.540(a)(4), which permits deactivation if the provider/supplier is not in compliance with all enrollment requirements. See sections 10.4.8(B) and (D) below for more information on this new deactivation ground.)
- (iv) The provider/supplier deactivates an EFT agreement and remains enrolled but does not submit a new EFT agreement within 90 days. (The deactivation basis shall be 42 CFR § 424.540(a)(4).)

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

(vi) The provider or supplier is voluntarily withdrawing from Medicare, and a situation arises where: (1) a particular instruction in this chapter calls for deactivation due to the voluntary withdrawal; and (2) said directive does not require obtaining PEOG approval prior to the deactivation. (See reference to 42 CFR § 424.540(a)(7) below.)

(vii) The provider's or supplier's license has expired and the provider or supplier has not billed while the license was expired. (The deactivation basis shall be 42 CFR § 424.540(a)(4).)

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

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

1. Grounds

Section 424.540(a) lists eight deactivation grounds:

Section 424.540(a)(1) - The provider/supplier does not submit any Medicare claims for 6 consecutive calendar months. The 6-month period will begin the 1st day of the 1st month without a claim submission through the last day of the 6th month without a submitted claim.

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

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

Section 424.540(a)(3) - The provider/supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

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

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

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

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

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

C. Effective Dates

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

The effective dates of a deactivation are as follows:

- a. Non-Billing (§ 424.540(a)(1)) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the deactivation is imposed.
- b. Section 424.540(a)(2), (3), and (4) (see subsection (B) above) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider/supplier became non-compliant (e.g., the day after the expiration of the 90-day period in which the provider was required to report a change of information).
- c. Section 424.540(a)(5) – Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider’s/supplier’s practice location became non-operational or otherwise invalid.
- d. Section 424.540(a)(6) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date of death of the provider/supplier.
- e. Section 424.540(a)(7) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date on which the provider/supplier voluntarily withdrew from Medicare.
- f. Section 424.540(a)(8) - Unless stated otherwise in this chapter or in another CMS directive, the effective date is the date of the sale. (Note that PEOG will ultimately determine this effective date during its review of the case per subsection (F) below.)

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

D. Sections 424.540(a)(4) and (a)(5)

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

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

E. Section 424.540(a)(7)

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

F. Section 424.540(a)(8)

See section 10.6.1.1.5 of this chapter for information regarding seller CHOWs.

G. Miscellaneous

1. Except for deactivations under § 424.540(a)(8) (see § 424.550(b)(1)) and § 424.540(a)(7), the deactivation of Medicare billing privileges does not affect a provider/supplier's participation agreement.
2. Prior to deactivating an HHA's billing privileges for any reason (including under the "36-month rule"), the contractor shall refer the matter to its PEOG BFL for review and approval. The only exception for PEOG BFL review and approval is a deactivation due to failure to comply with a revalidation request.
3. Notwithstanding any other instruction to the contrary in this chapter, the provider/supplier may submit a rebuttal for deactivations imposed pursuant to § 424.540(a)(7) or (8). For these two rebuttal reasons, the contractor shall abide by the rebuttal policies in section 10.4.8.1. Note, however, that any such rebuttal only applies to the deactivation of billing privileges and not to the provider agreement termination.

10.4.8.1 – Deactivation Rebuttals

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Background

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

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

B. Notification Letters for Deactivations

If a basis is found to deactivate a provider's or supplier's Medicare billing privileges under one of the regulatory authorities in 42 C.F.R. § 424.540, the contractor shall deactivate the provider/supplier unless another CMS directive applies. If a revocation authority is applicable, the contractor shall follow the instructions in sections 10.4.7 and 10.4.8 et seq. of this chapter in lieu of deactivating the enrollment. If no revocation authority applies, the contractor shall send notification of the deactivation using the applicable model deactivation notice. The contractor shall send a notification letter for every deactivated enrollment. The contractor shall ensure the deactivation notice contains sufficient details so it is clear why the

provider's or supplier's Medicare billing privileges are being deactivated. The contractor shall send the deactivation notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor should also send the notice via fax if a valid fax number is available. All notifications shall be saved in PDF format, and all notification letters shall be mailed on the same date listed on the letter.

C. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Pursuant to 42 C.F.R. § 424.546(b), to be accepted and processed, the rebuttal submission must:

- (1) Be in writing;
- (2) Specify the facts or issues concerning the rebuttal with which the provider or supplier disagrees, and the reasons for disagreement;
- (3) Include all documentation the provider or supplier wants CMS to consider in its review of the deactivation;
- (4) Be submitted in the form of a letter that is signed and dated by the individual supplier (if enrolled as an individual physician or nonphysician practitioner), the authorized official or delegated official (as those terms are defined in 42 CFR 424.502), or a legal representative (as defined in 42 C.F.R. 498.10);
 - If the legal representative is an attorney, the attorney must include a statement that he/she/they have the authority to represent the provider or supplier; this statement is sufficient to constitute notice of such authority.
 - If the legal representative is not an attorney, the provider or supplier must file with CMS written notice of the appointment of a representative; this notice of appointment must be signed and dated by, as applicable, the individual supplier, the authorized official or delegated official, or a legal representative.
 - Authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.
 - Signatures may be original or electronic. Valid signatures include handwriting (wet) signatures in ink and digital/electronic signatures. Digital or electronic signatures such as those created by digital signature options, created in software, such as Adobe) and email signatures shall be accepted. Contractors shall contact ProviderEnrollmentAppeals@cms.hhs.gov for questions regarding electronic and digital signatures.
- (5) Be received by the contractor within 15 calendar days from the date of the deactivation notice. The contractor shall accept a rebuttal submission via hard-copy mail, e-mail, and/or fax;

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

If a rebuttal submission: (1) is not appropriately signed and no response is received to the development request (if applicable); (2) is untimely (as described above); (3) does not specify the facts or issues with which the provider/supplier disagrees and the reasons for disagreement and no response is received to the development request; or (4) is a duplicative submission, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter. For those rebuttal submissions that are improperly signed and/or do not specify the facts or issue with which the provider or supplier disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider/supplier requesting a proper signature and/or clarification on the facts or issues with which the provider or supplier disagrees and the reasons for disagreement using the applicable Rebuttal Development Model Letter. Sending the development letter via fax is optional. The contractor shall grant an additional 15-calendar days from the date of the development request letter for the provider or supplier to submit an acceptable rebuttal submission. If no response is received or the rebuttal submission is still deficient after the development request and the 15-calendar day timeframe has expired, the contractor shall dismiss the rebuttal submission using the applicable Rebuttal Dismissal Model Letter.

The contractor may make a good cause determination to accept any rebuttal that has been submitted beyond the 15 calendar-day filing timeframe. Good cause may be found where there are circumstances beyond the provider's or supplier's control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider/supplier's failure to timely update its enrollment information, specifically its various addresses. If the contractor believes good cause exists to accept an untimely rebuttal submission, the contractor shall send a request approval email to ProviderEnrollmentAppeals@cms.hhs.gov within five calendar days of making the good cause determination. This email shall detail the contractor's reasoning for finding good cause. Processing timeliness standards shall begin on the date the contractor receives a response from CMS.

2. Time Calculations for Rebuttal Submissions

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

It is the provider's or supplier's responsibility to timely update his/her/their/its enrollment record to reflect any changes to the provider's or supplier's enrollment information including, but not limited to, its correspondence address. Failure to timely update a correspondence address or other addresses included in its Medicare enrollment record does not constitute an "in fact" showing that the deactivation notice was received after the presumed receipt date (as described above).

3. Processing Rebuttal Submissions

The contractor shall send an acknowledgement letter via hard-copy mail to the return address on the rebuttal submission within 10 calendar-days of receipt of the accepted rebuttal request using the Rebuttal Acknowledgment Model Letter, including a rebuttal tracking number and the provider's or supplier's NPI. The acknowledgement letter shall also be sent via email if a valid email address is available (either in the enrollment record or rebuttal submission). It is optional for the contractor to send the acknowledgement letter via fax if a valid fax number is available. If a rebuttal determination is issued within 10 calendar-days of the date of receipt of the rebuttal submission then the contractor is not required to issue a receipt acknowledgement letter.

The contractor shall process all accepted rebuttal submissions within 30 calendar-days of the date of receipt. If, while reviewing the rebuttal submission, the provider or supplier wishes to

withdraw its rebuttal, the request to withdraw must be submitted to the contractor in writing before the rebuttal determination is issued. If a provider or supplier submits a written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination then the contractor shall issue a letter using the applicable Rebuttal Withdrawn Model Letter and no rebuttal determination shall be issued.

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

4. Reason-Specific Instructions

a. § 424.540(a)(1)

For deactivations under § 424.540(a)(1), the contractor shall review submitted documentation and internal systems to confirm whether billing occurred during the 6-month period preceding the date of deactivation, starting with the first day of the first month 6 months prior to the date of deactivation. If it is confirmed that billing occurred within 6 months, the contractor shall issue a favorable rebuttal determination. If no billing occurred during the 6-month period prior to the date of deactivation, the contractor shall issue an unfavorable rebuttal determination. Consider the following illustration:

EXAMPLE: Dr. Awesome has been enrolled in Medicare since 2010. A review of billing data reveals that Dr. Awesome has not submitted any Medicare claims since January 2019. Dr. Awesome's enrollment is deactivated, under 42 C.F.R. § 424.540(a)(1), effective January 1, 2020. Dr. Awesome timely submits a rebuttal in response to the deactivation. Upon review by the contractor, it is confirmed that Dr. Awesome had not submitted claims since January 2019. Therefore, an unfavorable rebuttal determination would therefore be appropriate in this scenario, for the deactivation was appropriate.

b. § 424.540(a)(2)

For deactivations under § 424.540(a)(2), the contractor shall review the submitted documentation and internal records to determine whether the change of information was properly submitted within the required timeframe. The required timeframe to submit updated information is described at 42 C.F.R. §§ 424.550, 410.33(g)(2), 424.57(c)(2), and 424.516(d). If information was submitted properly and timely, the contractor shall approve the rebuttal submission, issue a favorable rebuttal determination, and reinstate the provider's or supplier's Medicare billing privileges to an approved status. If it was not submitted properly and timely, the contractor shall deny the rebuttal request and issue an unfavorable rebuttal determination, as the deactivation was appropriate. In making this determination, the contractor shall consider, at minimum, the following.

- Whether the deactivation was implemented after the required timeframe to report a change of enrollment information elapsed;
- Whether the letter notifying the provider/supplier of the deactivation was sent to the correct address as instructed in section 10.7 et seq. of this chapter; and
- Whether the enrollment changes were received in an enrollment application that was processed to completion within the required timeframe.

Consider the following illustration:

EXAMPLE: Dr. Happy has reassigned his benefits to a physician group, Smile, LLC. Smile, LLC is Dr. Happy's only reassignment and only practice location. Smile, LLC's enrollment and corresponding billing privileges are revoked effective January 1, 2018. Dr. Happy's

enrollment is deactivated on February 1, 2018 for failing to update his enrollment record with respect to his practice location. Dr. Happy timely submits a rebuttal in response to the deactivation of his individual enrollment. Upon review by the contractor of the submitted documentation and internal records, it is discovered that Dr. Happy submitted a change of information application received by the contractor on February 28, 2018 that sought to update his practice location. However, this application was ultimately rejected due to his failure to timely respond to a development request.

In this scenario, the deactivation was correctly implemented after 30 days of the change of enrollment information – the change in practice location. However, an enrollment application updating Dr. Happy’s practice location that was processed to completion was not received within 30 days of the change of enrollment information. Though the contractor received an application within 30 days of the change of enrollment information, that application was not processed to completion. Thus, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was appropriately implemented.

c. § 424.540(a)(3)

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

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

Consider the following scenario:

EXAMPLE: On January 1, 2022, the contractor appropriately and timely informs Dr. Great that the contractor must receive a revalidation application from Dr. Great by April 15, 2022. The contractor receives a revalidation application from Dr. Great on March 1, 2022. The contractor requests that Dr. Great furnish further information needed to process the revalidation application. Dr. Great does not respond to the development request within 30 days as requested. The contractor rejects the March 1, 2022 revalidation application and subsequently deactivates Dr. Great’s enrollment on April 16, 2022 under 42 C.F.R. § 424.540(a)(3). Dr. Great timely files a rebuttal in response to the deactivation. Upon review of the submitted documentation and internal records, the contractor confirms that Dr. Great was appropriately and timely notified of the requirement to revalidate and that it did not receive a revalidation application within 90 days of the revalidation request that could be processed to completion. Accordingly, an unfavorable rebuttal determination would be appropriate in this scenario, as the deactivation was appropriately implemented.

d. § 424.540(a)(4) and (5)

For deactivations under § 424.540(a)(4), the contractor shall review all submitted documentation and internal records to determine whether the provider or supplier was, in fact, compliant with all enrollment requirements at the time of the deactivation

For deactivations under § 424.540(a)(5), the contractor shall review all submitted documentation and internal records to determine whether the provider's or supplier's practice location was operational or otherwise valid at the time of the deactivation.

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

e. § 424.540(a)(6)-(8)

Although rebuttals under § 424.540(a)(6)-(8) these three deactivation grounds are uncommon, the provider or supplier may submit one. Upon receipt of a rebuttal submission, the contractor shall review all submitted documentation and internal records to determine whether the deactivation pursuant to the regulatory basis in question was appropriate. If it was not, the contractor shall approve the rebuttal request and reinstate the provider/supplier's Medicare billing privileges to an approved status; prior PEOG review of the rebuttal or approval of the rebuttal request is not required. If the rebuttal was not submitted properly and timely, the contractor shall dismiss the rebuttal request.

D. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate Model Rebuttal Decision Letter. If the contractor is unable to render a determination, the contractor shall use the appropriate Model Letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent (1) via hard-copy mail to the return address on the rebuttal submission; (2) via hard-copy mail to the correspondence mailing address on the enrollment records (if different from return address on rebuttal submission); and (3) by e-mail if a valid e-mail address is available (submitted as part of the rebuttal submission and/or listed in the enrollment record correspondence mailing address). The contractor may also send via fax if a valid fax number is available. All documentation shall be saved in PDF format. All notification letters shall be mailed on the same date listed on the letter.

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

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

If additional information/documentation is needed prior to reinstating the provider or supplier as part of a favorable rebuttal determination (e.g., deactivation due to non-response to

revalidation and a complete application or missing information is needed to finalize the revalidation), the contractor shall document these next steps in its rebuttal determination letter. The contractor shall not reinstate the provider or supplier until the requested information is received and processed. If the additional information/documentation is not received within 30 calendar days of the date of the rebuttal determination, the contractor shall contact the provider/supplier to again request the additional information/documentation within 10 calendar days of not receiving a response.

If no response is received within 30 calendar days of the second request for additional information/documentation, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within 10 calendar days for further instruction.

E. No Further Review

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

F. External Monthly Reporting for Rebuttals

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all rebuttal submissions received and processed by the contractor. No column shall be left blank (except Column K, as described below). If the contractor is unable to complete all columns for a given rebuttal submission, the contractor shall contact ProviderEnrollmentAppeals@cms.hhs.gov within five business days of discovery to seek further guidance.

The reports shall use only the formats identified below. All dates shall be formatted as mm/dd/yyyy (e.g. 01/13/2021). The reports shall be sent to CMS via email at ProviderEnrollmentAppeals@cms.hhs.gov no later than the 15th of each month. If this day falls on a weekend or a holiday, the report shall be submitted the following business day. The report shall include the prior month's rebuttal submissions, as well as outcomes for all submissions previously received that were not yet completed and reported to CMS (e.g., the February report shall cover all January rebuttals).

IMPORTANT: All submissions shall remain on the monthly report until a final outcome/decision has been reported to CMS.

- **Column A:** The response in Column A labelled, "Provider/Supplier Name (As it appears in PECOS)" shall be the provider's or supplier's Legal Business Name, exactly as it is spelled and formatted in the PECOS enrollment record (including capitalization, abbreviations, and punctuation).
- **Column B:** The response in Column B labelled, "NPI" shall be the provider's or supplier's NPI. If the provider/supplier has more than one NPI, the contract shall list each NPI, separated by a semi-colon.
- **Column C:** The response in Column C labelled, "EID (if applicable)" shall be the provider's or supplier's EID. If there is no EID associated with the provider/supplier, the response shall be "N/A".
- **Column D:** The response in Column D labelled, "PTAN(s) (if applicable)" shall include the provider's or supplier's PTAN. If the provider/supplier has more than one PTAN, each PTAN shall be separated by a semicolon (e.g. L5988; 190002033). If the provider/supplier does not have a PTAN, the response shall be "N/A".

- **Column E:** The response in Column E labelled, “Contractor (Including Jurisdiction),” shall be in one of the following formats. No other formats are acceptable.
 - CGS J15
 - FCSO
 - NGS J6
 - NGS JK
 - Noridian JE
 - Noridian JF
 - Novitas JH
 - Novitas JL
 - NPE East
 - NPE West
 - NSC
 - Palmetto JJ
 - Palmetto JM
 - WPS J5
 - WPS J8

- **Column F:** The response in Column F labelled, “Regulatory Authority for Deactivation,” shall be in the following format. If the response is “Other (see Comments)” the Contractors shall use Column K to provide explanatory notes (e.g. when a rebuttal is submitted in response to an enrollment action that does not afford rebuttal rights, describe the enrollment action in Column K). No other formats are acceptable:
 - 424.540(a)(1)
 - 424.540(a)(2)
 - 424.540(a)(3)
 - 424.540(a)(4)
 - 424.540(a)(5)
 - 424.540(a)(6)
 - 424.540(a)(7)
 - 424.540(a)(8)
 - Other (see Comments)

- **Column G:** The response in Column G labelled, “Date Rebuttal Received” shall be the date on which the Contractor received the rebuttal. The date shall be formatted as mm/dd/yyyy (e.g. 10/25/2021).

- **Column H:** The response in Column H labelled, “Date Receipt Acknowledgement Sent to Provider/Supplier/Legal Representative,” shall be “Not yet sent” if a receipt acknowledgement email/letter has not been sent to the provider/supplier/legal representative at the time the monthly report is sent to CMS. The response shall be “N/A” if a receipt acknowledgement email/letter is not required for that case (i.e., rebuttal determination is issued within 10-calendar days of the date of receipt of the rebuttal submission). Dates shall be formatted as mm/dd/yyyy (e.g. 06/15/2020).

- **Column I:** The response in Column I labelled, “Date Rebuttal Determination Issued” shall be the date on which the Contractor issues the rebuttal determination. The date shall be formatted as mm/dd/yyyy (e.g. 09/19/2019). If a final rebuttal determination has not yet been issued, the contractors shall enter "In Process" as the response.

- **Column J:** The response in Column J labelled, “Final Decision Result,” shall be one of the following. No other formats are acceptable.

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved (e.g. deactivation was rescinded).
 - **Favorable:** (to provider/supplier) Contractor has determined that an error was made in the implementation of the deactivation. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status.
 - **Unfavorable:** (to provider/supplier) Contractor upholds the initial determination resulting in the enrollment remaining deactivated.
 - **Dismissed:** The rebuttal submission does not meet the rebuttal submission requirements (e.g. missing proper signature and did not timely respond to development request).
 - **Withdrawn:** Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledge the withdrawal.
 - **In Process:** A final decision has not been issued. The Contractor is still processing the submission.
- **Column K:** The response in Column K labelled, “Comments,” shall include any information related to the deactivation, rebuttal submission, or rebuttal determination that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.6.1.1 – Changes of Ownership (CHOWs) – Transitioned Certified Providers and Suppliers

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

(Until further notice from CMS, the instructions in sections 10.6.1.1 through 10.6.1.1.4 apply only to certified provider and certified supplier types that have officially “transitioned” as part of the transition of various certification activities from the SOG Location to the states, the contractors, and PEOG. These provider/supplier types include SNFs, HHAs, CMHCs, CORFs, Part A OPT/OSP, ASCs, and PXRSS. The contractor shall continue to use the existing CHOW instructions--now in section 10.6.22 of this chapter--for all non-transitioned certified provider/supplier types.

When executing the instructions in sections 10.6.1.1 through 10.6.1.1.4, the contractor can disregard directives that obviously do not apply to the provider/supplier type in question (e.g., references to home health agencies do not apply to SNFs).

Except as otherwise noted, the term “CHOW” as used in section 10.6.1.1 et seq. includes CHOWs, acquisitions/mergers, and consolidations. Though the Change of Ownership (CHOW) Information section of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers, and consolidations for ease of disclosure and reporting, they fall within the general CHOW category under 42 CFR § 489.18 (e.g., an acquisition/merger is a type of CHOW under § 489.18).

Note that the CHOW instructions in 10.6.1.1 through 10.6.1.1.4 apply to HHA *and hospice* CHOWs taking place under 42 CFR § 489.18. For changes in majority ownership under 42 CFR § 424.550(b), see section 10.2.1.6.1 of this chapter.

10.6.1.1.5 – HHA and Hospice Ownership Changes

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Background – 36-Month Rule

1. General Principles

In accordance with 42 CFR § 424.550(b)(1), if there is a change in majority ownership of an HHA or hospice by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's or hospice's initial enrollment in Medicare or within 36 months after the HHA's or hospice most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA or hospice must instead:

- Enroll in the Medicare program as a new (initial) HHA or hospice under the provisions of § 424.510, and*
- Obtain a state survey or an accreditation from an approved accreditation organization.*

For purposes of § 424.550(b)(1), a “change in majority ownership” (as defined in 42 CFR § 424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA or hospice during the 36 months following the HHA's or hospice's initial enrollment into the Medicare program or the 36 months following the HHA's or hospice's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA or hospice through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's or hospice's most recent change in majority ownership.

2. Exceptions

There are several exceptions to § 424.550(b)(1). Specifically, the requirements of § 424.550(b)(1) do not apply if:

- The HHA or hospice has submitted 2 consecutive years of full cost reports since initial enrollment or the last change in majority ownership, whichever is later. (For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports.)*
- The HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.*
- The HHA or hospice is changing its existing business structure – such as from a corporation, a partnership (general or limited), or a limited liability company (LLC) to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.*
- An individual owner of the HHA or hospice dies.*

In addition, § 424.550(b)(1) does not apply to “indirect” ownership changes.

3. Timing of 36-Month Period for Hospices

The provisions of 42 CFR § 424.550(b)(1) and (2) with respect to hospices (as enacted in “CMS-1780-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2024”) became effective January 1, 2024. This means these provisions impact only those hospice ownership transactions whose effective date is on or after January

1, 2024. However, the provisions can apply irrespective of when the hospice first enrolled in Medicare. Consider the following illustrations:

- *Example 1 – Smith Hospice initially enrolled in Medicare effective February 1, 2022. Smith undergoes a change in majority ownership effective February 1, 2024. The provisions of § 424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.*
- *Example 2 – Jones Hospice initially enrolled in Medicare effective February 1, 2016. Jones undergoes its first change in majority ownership effective February 1, 2024. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones’s initial enrollment. Suppose, however, that Jones undergoes another change in majority ownership effective February 1, 2025. Section 424.550(b)(1) applies to this transaction because it took place within 36 months after Jones’s most recent change in majority ownership (i.e., on February 1, 2024).*
- *Example 3 – Davis HHA initially enrolled in Medicare effective February 1, 2012. It underwent its first change in majority ownership effective February 1, 2016. This change was not affected by § 424.550(b)(1) because it occurred more than 36 months after Davis’s initial enrollment. Davis underwent another change in majority ownership effective February 1, 2023. This change, too, was unaffected by § 424.550(b)(1), for it occurred more than 36 months after the HHA’s most recent change in majority ownership (i.e., on February 1, 2016). Davis underwent another majority ownership change on February 1, 2025. This change is impacted by § 424.550(b)(1), since it occurred within 36 months of the HHA’s most recent change in majority ownership (i.e., on February 1, 2023).*

B. Determining the 36-Month Rule’s Applicability

If the contractor receives a Form CMS-855A application reporting an HHA or hospice ownership change (and unless a CMS instruction or directive states otherwise), it shall undertake the following steps:

Step 1 – Change in Majority Ownership

The contractor shall determine whether a change in direct majority ownership has occurred. Through its review of the transfer agreement, sales agreement, bill of sale, etc., the contractor shall verify whether:

- *The ownership change was a direct ownership change and not a mere indirect ownership change, and*
- *The change involves a party assuming a greater than 50 percent ownership interest in the HHA or hospice.*

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of three ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA or hospice, this would constitute a change in majority ownership. This is consistent with the verbiage in the aforementioned definition of “change in majority ownership” regarding the “cumulative effect” of asset sales, transfers, etc. Another example of a change in majority ownership would be if a 50 percent owner obtains any additional amount of ownership (regardless of the percentage) and hence becomes a majority owner; thus, for

instance, if a 50 percent owner were to acquire an additional .001 percent ownership stake, he or she becomes a majority owner and the transaction involves a change in majority ownership.

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally (which will typically be as a change of information under 42 CFR § 424.516(e)). If it does qualify, the contractor shall proceed to Step 2:

Step 2 – 36-Month Period

The contractor shall determine whether the effective date of the transfer is within 36 months after the effective date of the HHA's or hospice's (1) initial enrollment in Medicare or (2) most recent change in majority ownership. The contractor shall verify the effective date of the reported transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application. It shall also review its records – and, if necessary, request additional information from the HHA or hospice – regarding the effective date of the HHA's or hospice's most recent change in majority ownership, if applicable.

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) or as a potential change of ownership under 42 CFR § 489.18.

If the transfer's effective date falls within one of these 36-month timeframes, the contractor shall proceed to Step 3.

Step 3 – Applicability of Exceptions

If the contractor determines that a change in majority ownership has occurred within either of the above-mentioned 36-month periods, the contractor shall determine whether any of the exceptions in § 424.550(b)(2) apply. As alluded to earlier, the exceptions are as follows:

i. The HHA or hospice has submitted 2 consecutive years of full cost reports.

(A) For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. (See 42 CFR § 413.24(h) for a definition of low Medicare utilization.)

(B) The cost reports must have been: (1) consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer; and (2) accepted by the contractor.

ii. The HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

iii. The HHA or hospice is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

(A) If the HHA or hospice is undergoing a change in business structure other than those which are specifically mentioned in this exemption (e.g., corporation to an LLC), the contractor shall contact its PEOG Business Function Lead (BFL) for guidance.

(B) For the exemption to apply, the owners must remain the same.

iv. An individual owner of the HHA or hospice dies – regardless of the percentage of ownership the person had in the HHA or hospice.

Step 4 - Determination

If the contractor concludes that one of the aforementioned exceptions applies (and unless a CMS instruction or directive states otherwise), it may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) (via the instructions in section 10.6.1.2 of this chapter) or as a potential change of ownership under 42 CFR § 489.18 (via the instructions in section 10.6.1.1 of this chapter).

If no exception applies, the contractor shall refer the case to its PEOG BFL for review. Under no circumstances shall the contractor apply the 36-month rule to the HHA or hospice and require an initial enrollment based thereon without the prior approval of PEOG. If PEOG agrees with the contractor's determination:

(1) PEOG will terminate the seller in ASPEN.

(2) The contractor shall identify the voluntary termination action in PECOS as a deactivation --- and hence shall deactivate the HHA's or hospice's billing privileges pursuant to § 424.540(a)(8) --- with a status reason of "Voluntarily Withdrawal from the Medicare Program." Per § 424.540(d)(1)(ii)(E), the effective date of the deactivation shall be the date of the sale.

(3) The contractor shall send to the HHA or hospice the "36-Month Rule Voluntary Termination Letter" in section 10.7.5.1. This letter will include, among other things, rebuttal rights regarding the deactivation as well as language stating that, as a result of § 424.550(b)(1), the HHA or hospice must:

- Enroll as an initial applicant; and*
- Obtain a new state survey or accreditation survey after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the state.*

(In preparing this letter, the contractor may, if applicable to the situation, change any reference therein to "HHA" or "home health agency" to "hospice.")

(4) The HHA or hospice need not submit a Form CMS-855A voluntary termination application.

Providers and/or their representatives (e.g., attorneys, consultants) shall contact their local MAC with any questions concerning (1) the 36-month rule in general and (2) whether the rule and/or its exceptions apply in a particular provider's case.

C. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA or hospice ownership change by means other than the submission of a Form CMS-855A application, it shall notify its PEOG BFL immediately.

2. If the contractor determines, under Step 3 above, that one of the § 424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It underwent a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from § 424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA underwent another change in majority ownership that did not qualify for an exception. The HHA thus had to enroll as a new HHA under § 424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from § 424.550(b)(1).

10.6.7.2 – Individual Owning and Managing Information

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Owning and Managing Individuals Who Must Be Listed in this Section

All individuals who have any of the following must be listed in this section:

- (i) Ownership** - A 5 percent or greater direct or indirect ownership interest in the provider.
- (ii) Mortgage/Security Interest** - A 5 percent or greater mortgage or security interest in the provider.

(iii) Partnership Interests

- Any general partnership interest in the provider, regardless of the percentage. This includes (1) all interests in a non-limited partnership and (2) all general partnership interests in a limited partnership.
- Limited partnerships - For the CMS-855A, any limited partnership interest that is 10 percent or greater. For the Form CMS-855B, CMS-855S and CMS-20134, any limited partnership interest, regardless of the percentage.

(iv) Managing Control of the Provider - For purposes of enrollment, such a person is considered to be a “managing employee.” A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.

(v) Corporate Officers and Directors/Board Members

Officers and directors/board members must be listed in the Individual Ownership and/or Managing Control section if – and only if - the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors. If a non-profit corporation has “trustees” instead of officers or directors, these trustees must be listed in this section of the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.)

Only the enrolling provider's officers and directors must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in this section. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board

members. In such cases – and again assuming that the provider is a corporation – the indirect owner’s officers and directors/board members would have to be disclosed as the provider’s officers and directors/board members in this section.

With respect to corporations, the term “director” refers to members of the board of directors. If a corporation has, for instance, a Director of Finance who nonetheless is not a member of the board of directors, he/she would not need to be listed as a director/board member in this section. However, he/she may need to be listed as a managing employee in this section.

(See sections 10.6.7.1(A) of this chapter for more information on direct and indirect ownership, mortgage and security interests, and partnerships.)

B. Specific Reporting Policies

1. Proof of Owning/Managing Control and Percentages – Proof of ownership interest, partnership interest, managerial control (including W-2s and other proof of employment), security interest, percentage of ownership or control, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor’s request.
2. Government Entities – Government entities need only report their managing employees, for they do not have owners, partners, corporate officers, or corporate directors.
3. Minimum Number of Managing Employees - The provider must report all managing employees but must have at least one if it is completing the Form CMS-855A, CMS-855B, CMS-855S, or CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if he/she does not have one.
4. Practice Locations on the Form CMS-855I - All managing employees at all practice locations listed in the Business Information/Practice Location Information section of the Form CMS-855I must be reported in the Managing Employee Information section. The only exceptions to this are individuals who are (a) employed by hospitals, health care facilities, or other organizations shown in the Business Information/Practice Location Information section (e.g., the chief executive officer of a hospital listed in this section) or (ii) managing employees of any group/organization to which the practitioner will be reassigning his/her benefits; these persons need not be reported.
5. Partnership Interests Involving Indirect Owners - Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider’s indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be reported.
6. Ownership Disclosures – Concerning ownership disclosures, the contractor shall adhere to the instructions in section 10.6.7.1(D)(6).

10.6.15 – Risk-Based Screening

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

Consistent with 42 CFR § 424.518, newly-enrolling and existing providers and suppliers will, beginning on March 25, 2011, be placed into one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor’s screening of the provider when it initially enrolls in Medicare, adds a new practice location, revalidates its enrollment information, or, in certain circumstances, changes all or part of its ownership.

A. Specific Screening Categories

1. Limited Risk

The “limited” level of categorical screening consists of the following provider and supplier types:

- Physicians
- Non-physician practitioners other than physical therapists
- Physician group practices
- Non-physician group practices other than physical therapist group practices
- Ambulatory surgical centers
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease facilities
- Federally qualified health centers
- Histocompatibility laboratories
- Home infusion therapy suppliers
- Hospitals (including critical access hospitals, rural emergency hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities).
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Outpatient physical therapy/outpatient speech pathology providers enrolling via the Form CMS-855A
- Pharmacies that are newly enrolling or revalidating via the Form CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics

For providers and suppliers in the “limited” category, the contractor shall process initial, revalidation, and new location applications in accordance with existing instructions.

2. Moderate Risk

a. General Information

The “moderate” level of categorical screening consists of the following provider and supplier types:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRSSs)
- Newly Enrolling Opioid Treatment Program (OTP) that were SAMSHA certified prior to October 24, 2018
- Revalidating home health agencies (HHAs)

- *Revalidating hospices*
- Revalidating DMEPOS suppliers
- Revalidating MDPP suppliers
- Revalidating OTP providers
- Revalidating SNFs
- *Pursuant to § 424.518(b)(1)(ix), revalidating OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS suppliers, revalidating MDPP suppliers, revalidating HHAs, revalidating SNFs, and revalidating hospices to which CMS applied the fingerprinting requirements outlined in § 424.518(c)(2)(ii) upon the provider's or supplier's—*
 - *New/initial enrollment; or*
 - *Revalidation after CMS waived the fingerprinting requirements, under the circumstances described in § 424.518(c)(1)(viii), when the provider or supplier initially enrolled in Medicare. (See subsection (A)(5) below for more information.)*

For providers and suppliers in the “moderate” level of categorical screening, the contractor shall (unless section 10.6.15(A)(4) of this chapter or another CMS directive applies): (1) process initial, revalidation, and new location applications in accordance with existing instructions; and (2) order an NSVC site visit through PECOS consistent with subsection 2(b) below. (Unless stated otherwise in this chapter, the scope of the site visit shall be consistent with existing instructions.)

b. Provider/Supplier-Specific Information

(i) Ambulance suppliers, independent clinical laboratories, physical therapists, and physical therapist groups

If the supplier submits an initial application, revalidation application, or application to add a new practice location, the contractor shall order a site visit. (For new location additions, the site visit shall be of the new location.) The contractor shall not make a final decision regarding the application (or, for initial applications, shall not convey Medicare billing privileges) prior to the completion of the NSVC's site visit and the contractor's review of the results.

(ii) CMHCs, CORFs, Hospices and PXRSSs

For site visits regarding these four provider/supplier types, the contractor shall adhere to the site visit instructions in, respectively, sections 10.2.1.1, 10.2.1.2, 10.2.1.7, and 10.2.2.8 of this chapter.

(iii) IDTFs

Initial applications - The NSVC will conduct site visits of initially enrolling IDTFs consistent with section 10.2.2(O)(15) of this chapter.

Revalidations - The NVSC will conduct site visits of revalidating IDTFs (prior to the contractor's final decision regarding the revalidation application) consistent with section 10.2.2(I)(15) of this chapter.

IDTF Code Changes - The NSVC will conduct site visits for IDTF code changes as specified in section 10.2.2(I)(17) of this chapter.

(iv) Revalidating HHAs and SNFs

For site visits regarding revalidating HHAs and SNFs, the contractor shall adhere to the site visit instructions in, respectively, sections 10.2.1.6 and 10.2.1.14 of this chapter.

(v) Revalidating DMEPOS Suppliers

A site visit of the DMEPOS supplier shall be conducted prior to the NSC making a final decision regarding the revalidation application.

(vi) Revalidating MDPP Suppliers

If an MDPP supplier submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

(vii) Revalidating OTP Providers

If an OTP provider submits a revalidation application, the contractor shall order a site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. High Risk

a. General Information

Pursuant to 42 CFR § 424.518, the "high" level of categorical screening consists of the following provider and supplier types:

- Newly enrolling DMEPOS suppliers
- Newly enrolling HHAs (including HHAs that must submit an initial enrollment application pursuant to § 424.550(b)(1))
- *Newly enrolling hospices*
- Newly enrolling MDPP suppliers
- Newly enrolling OTP providers that were SAMSHA certified after October 24, 2018
- Newly enrolling SNFs
- DMEPOS suppliers, HHAs, MDPP suppliers, OTP providers that were SAMSHA certified after October 24, 2018, SNFs, and *hospices* submitting either: (i) a change of ownership application pursuant to 42 CFR § 489.18; or (ii) an application to report any new owner (regardless of ownership percentage, though consistent with the definition of owner in section 10.1.1 of this chapter) pursuant to a change of information or other enrollment transaction under title 42.
- *Except as stated in § 424.518(b)(1)(ix), revalidating OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS suppliers, revalidating MDPP suppliers, revalidating HHAs, revalidating SNFs, and revalidating hospices for which, upon their new/initial enrollment, CMS waived the fingerprinting requirements outlined in paragraph (c)(2)(ii) of this section pursuant to applicable legal authority due to a national, state, or local emergency declared under existing law. (See subsection (A)(5) below for more information.)*

For newly enrolling providers and suppliers in the "high" level of categorical screening:

- (i) The contractor shall process the application in accordance with existing instructions.
- (ii) The NSVC will perform a site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the site visit and the contractor's review of the results.

(iii) Their 5 percent or greater direct and indirect owners must undergo fingerprint-based criminal background checks. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of fingerprinting and the contractor's review of the results.

(iv) The contractor shall, upon switching the provider's or supplier's enrollment record to "Approved," enter the provider's risk category as "moderate" into PECOS.

b. Additional Considerations

(i) Enrolled DMEPOS suppliers that are adding another location will be classified as "high" for screening purposes.

(ii) The addition of a new HHA branch falls within the "moderate" level of categorical screening. A site visit of the branch shall thus be performed consistent with the instructions in this chapter (including those in section 10.2.1.6).

(iii) The addition of a new MDPP supplier administrative location that does not result in a new PTAN does not require an additional site visit. Any additional MDPP supplier administrative location that results in a new PTAN, either due to being in a new jurisdiction or because of a new CDC organizational code, the contractors shall order a site visit of the location through PECOS. This is to ensure that the supplier is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider's enrollment record to "Approved" prior to the completion of the NSVC's site visit and the contractor's review of the results.

c. Changes of/in Ownership

As explained above and in more detail in section 10.6.21(E)(3), the "high" screening category includes DMEPOS suppliers, HHAs, MDPP suppliers, OTP providers that were SAMSHA certified after October 24, 2018, SNFs, *and hospices* submitting either: (i) a change of ownership application pursuant to 42 CFR § 489.18; or (ii) an application to report any new owner (regardless of ownership percentage, though consistent with the definition of owner in section 10.1.1 of this chapter) pursuant to a change of information or other enrollment transaction under title 42. Accordingly, any change of/in ownership that meets all of the following criteria would fall under (i) or (ii) above:

- Does not involve the triggering of an initial enrollment (e.g., an HHA *or hospice* change in majority ownership for which no exception applies requires a new enrollment); and
- The change reports either:
 - For partnerships: A new partner (general or limited) who owns any percentage (even 1 percent) of the provider/supplier; or
 - Excluding partnerships: A new direct or indirect owner of at least 5 percent of the provider/supplier.

Upon receipt of an application described above, the contractor shall process it consistent with the instructions in this chapter and this section 10.6.15. This includes requesting fingerprints from the new owner(s) if the owner has a 5 percent or greater direct or indirect ownership interest. However, the contractor need not also solicit them from the provider/supplier's existing owners; only the new owner(s) need be fingerprinted.

(Note that if a new partner is being reported but the partner owns less than 5 percent of the provider/supplier, the provider/supplier's application must still be processed at the high screening level. However, the new partner need not be fingerprinted. This is because fingerprinting only applies to 5 percent or greater direct or indirect owners. It is therefore possible that, in such a change of ownership transaction, no fingerprinting will have to be conducted at all.)

The contractor shall also order a site visit of the provider/supplier consistent with existing instructions. In terms of the timing of the HHA, SNF, *or hospice* site visit, however, the contractor shall adhere to the following:

- No State/SOG Location Approval Required – If the ownership change does not require state or SOG Location approval under existing CMS instructions (see sections 10.6.1.1, 10.6.1.2, 10.6.22, and 10.6.22.1 of this chapter for more information on this topic), the site visit shall be ordered and performed prior to the contractor's final decision regarding the application.
- State/SOG Location Approval Required - If the ownership change requires state or SOG Location approval under existing CMS instructions, the site visit shall be ordered and performed no later than 5 business days after the contractor receives notice of approval from the state or SOG Location but before the contractor switches the provider/supplier's enrollment record to an "Approved" status.

(See section 10.6.21(E)(3) of this chapter for more information.)

4. Elevating Existing Providers and Suppliers into the High-Risk Screening Category

a. Criteria for Raising Providers/Suppliers to High-Risk

Under § 424.518(c)(3), CMS may adjust (or "bump up") a particular provider or supplier's screening level from "limited" or "moderate" to "high" if any of the following occur:

- (i) CMS imposes a payment suspension on a provider or supplier at any time within the last 10 years;
- (ii) The provider or supplier:
 - Has been excluded from Medicare by the Office of Inspector General;
 - Had its billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by: (A) enrolling as a new provider or supplier; or (B) obtaining billing privileges for a new practice location;
 - Has been terminated or is otherwise precluded from billing Medicaid;
 - Has been excluded from any federal health care program; or
 - Has been subject to any final adverse action (as defined in § 424.502) within the previous 10 years.
- (iii) CMS lifts a temporary moratorium for a particular provider or supplier type, and a provider or supplier that was prevented from enrolling based on the moratorium applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

b. Extension of Application of a Provider/Supplier's "Bump-Up"

Effective January 6, 2023 (and pursuant to § 424.518(c)(4)), any screening level adjustment under § 424.518(c)(3) also applies to all other enrolled and prospective providers and suppliers that have the same legal business name (LBN) and tax identification number (TIN)

as the provider or supplier for which the screening level under § 424.518(c)(3) was originally raised. To illustrate, suppose an entity is enrolled as an ambulance supplier, a CORF, and a home infusion therapy (HIT) supplier. All three providers/suppliers are under the entity's TIN and LBN. The HIT supplier is under a payment suspension and is thus bumped-up to "high." Pursuant to § 424.518(c)(4), the ambulance supplier and CORF will also be moved to "high" because they have the same LBN and TIN as the HIT supplier.

c. List of Bumped-Up Providers/Suppliers

CMS makes available to the contractor on a bi-monthly basis a list of current and former Medicare providers and suppliers within the contractor's jurisdiction that have been "bumped-up" pursuant to § 424.518(c)(3) and (c)(4). Upon receipt of an initial or revalidation application from a provider or supplier that otherwise falls within the limited or moderate screening category (and after the appropriate fee has been paid, etc.), the contractor shall determine whether the provider or supplier is on the bi-monthly "high" screening list. If the provider or supplier is not on said list, the contractor shall process the application in accordance with existing instructions. If the provider or supplier is on the list, the contractor shall process the application using the procedures in the "high" screening category unless the provider is on the list solely because he/she/it was revoked for failing to timely respond to a revalidation request. If such is the case, the contractor shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL) for guidance as to how the situation should be handled.

d. Post-Moratorium Applications

If the contractor receives an initial or new location application from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium and (b) within 6 months after the applicable moratorium was lifted, the contractor shall process the application using the procedures in the "high" screening category.

5. Prior Waiver from Fingerprinting

During the recent COVID-19 public health emergency (PHE), CMS temporarily waived the requirement for fingerprint-based criminal background checks (FBCBCs) for 5 percent or greater owners of newly enrolling providers and suppliers falling within the high-risk screening category in § 424.518(c). CMS seeks to perform FBCBCs for high-risk providers and suppliers that initially enrolled during the PHE upon their revalidation once the PHE ends. This was not previously possible under our prior regulations because the revalidation applications would only be screened at the moderate-risk level. Pursuant to our regulatory revisions in the CMS CY 2024 Home Health Prospective Payment System final rule, however, CMS --- effective January 1, 2024 ---- may fingerprint the 5 percent or greater direct/indirect owners of these providers/suppliers. Specifically:

- (i) Revalidating OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS suppliers, revalidating MDPP suppliers, revalidating HHAs, revalidating SNFs, and revalidating hospices for which, upon their new/initial enrollment, CMS waived the fingerprinting requirements pursuant to a legally declared national, state, or local emergency declared under existing law --- These providers/suppliers fall within the high-risk screening category and are subject to the fingerprinting requirement as part of their revalidation requirement.*
- (ii) Once the providers/suppliers in (i) have been fingerprinted, they fall within the moderate-risk category.*

Upon receipt of an application from a revalidating OTP that has not been fully and continuously certified by SAMHSA since October 23, 2018, revalidating DMEPOS supplier, revalidating HHA, revalidating MDPP supplier, revalidating SNF, or revalidating hospice, the contractor shall determine whether the provider/supplier was waived from the fingerprinting requirement pursuant to applicable legal authority due to a national, state, or local emergency declared under existing law. If the provider/supplier was waived and has not yet been undergone fingerprinting, the contractor shall process the revalidation using the high-risk screening procedures. If the provider/supplier was not so waived or has otherwise undergone fingerprinting after a waiver, the revalidation application shall be processed consistent with the moderate-risk screening procedures.

Note that any such waiver must have been directed by CMS.

B. Changes of Information (Including Additions and Changes of Practice Locations)

(This subsection (B) does not apply to ownership changes that qualify as a mere change of information (e.g., reporting a new 10 percent owner.) These transactions are addressed in subsection (C) below.)

1. Limited

Changes of information (including additions of practice locations) submitted by providers/suppliers in the “limited” level of categorical screening shall be processed consistent with existing instructions.

2. Moderate

Changes of information submitted by providers/suppliers in the “moderate” level of categorical screening shall be processed consistent with existing instructions, although practice location additions and changes in a practice location’s physical location also require a site visit as described in this section 10.6.15. The site visit shall be performed consistent with the applicable instructions in this chapter (e.g., section 10.2.1.2 for CORFs). The contractor shall not make its final decision regarding the application prior to the completion of the site visit and the contractor’s review of the results.

3. High

Except as stated below, changes of information submitted by providers/suppliers in the “high” level of categorical screening shall be processed consistent with existing instructions, although practice location additions and changes in a practice location’s physical location also require a site visit as described in this section 10.6.15. The site visit shall be performed consistent with the applicable instructions in this chapter. The contractor shall not make its final decision regarding the application prior to the completion of the site visit and the contractor’s review of the results.

For purposes of this requirement:

- A change of location includes situations in which the provider/supplier is switching suite numbers or floors within a building. A site visit is required.
- If the provider/supplier’s physical location is not changing (e.g., the provider’s street name is changing but its actual office space is not), no site visit is required.
- A DMEPOS supplier that is adding a new practice location falls within the “high” screening category. This is because each location must be separately enrolled. The

enrollment of a new location thus constitutes an initial enrollment.

- A DMEPOS supplier undergoing a change in TIN with no change in ownership falls within the “moderate screening category.”

C. Change of Ownership

1. Limited

Changes of ownership (regardless of whether a new TIN is triggered) shall be processed consistent with existing instructions.

2. Moderate

If a provider or supplier is undergoing a change of ownership resulting in a new TIN, the contractor shall:

- a. Process the application consistent with existing instructions, and
- b. Order a site visit through PECOS in accordance with the following:
 - For ownership changes that must be approved by the state or SOG Location under current CMS instructions (see sections 10.6.1.1, 10.6.1.2, 10.6.22, and 10.6.22.1) of this chapter), the site visit shall be ordered and performed after the contractor receives notice of approval from the state or SOG Location but before the contractor switches the provider/supplier’s enrollment record to an “Approved” status. The contractor shall not switch the provider/supplier’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.
 - For ownership changes that do not require state or SOG Location approval under current CMS instructions, the site visit shall be ordered and performed prior to the contractor’s final decision regarding the application.

3. High

See subsection (A)(3)(c) for information on processing changes of/in ownership applications from DMEPOS suppliers, HHAs, MDPP suppliers, OTPs that have not been continuously SAMSHA-certified since October 24, 2018, SNFs, *and hospices*.

D. Reactivations

a. Limited

Form CMS-855 reactivation applications submitted by providers and suppliers in the “limited” level of categorical screening shall be processed in accordance with existing instructions.

b. Moderate

Form CMS-855 reactivation applications submitted by providers and suppliers in the “moderate” level of categorical screening – including existing DMEPOS suppliers, HHAs, MDPP suppliers, OTPs that have not been continuously SAMSHA-certified since October 24, 2018, and SNFs – shall be processed in accordance with the screening procedures for this category. A site visit will therefore be needed prior to the contractor’s final decision regarding the application.

c. High

Form CMS-855 reactivation applications submitted by providers and suppliers in the “high” level of categorical screening shall be processed in accordance with the screening procedures for this category. A site visit will therefore be needed prior to the contractor’s final decision regarding the application.

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

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

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

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

In addition:

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

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

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

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

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

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

(vii) For the Denial letter in section 15.7.5.1(H), the contractor shall indicate (in any manner it chooses) whether the denial pertains to the buyer's or the seller's application if a prospective CHOW was involved.

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

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

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

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

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

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

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

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

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

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

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

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

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [& AO, if applicable]

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

[Month, Day, Year]

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

Dear [Provider/Supplier],

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

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

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

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

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

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment and Provider/Supplier Specific Participation Agreement Information

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

Provider Transaction Access Number (PTAN)	
Enrollment Effective Date	

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

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to: ProviderEnrollmentAppeals@cms.hhs.gov

And

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

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

[Month, Day, Year]

[Provider/Supplier Name]
[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

We will contact you when we have a decision.

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

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

Sincerely,

[Name]

[Title]

[Company]

CC: State Agency [and AO, if applicable]

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

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

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

We will contact you when we have a decision.

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

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

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

Sincerely,

[Name]
 [Title]
 [Company]

CC: State Agency [and AO, if applicable]

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

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	

National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
PTAN Effective Date	
Changed Information	Include detailed changes or application section titles, as applicable.

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

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

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

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

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

(This letter only applies in cases where:

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

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

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

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

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

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

[REVOCATION AND/OR PROVIDER AGREEMENT TERMINATION RESULTING FROM THE APPLICATION SUBMISSION. As a result of the state's review, your provider/supplier agreement for participation in the Medicare program is terminated and your enrollment in the Medicare program is revoked for the following reason(s):

[INSERT DENIAL OR TERMINATION REASON GIVEN BY THE STATE AGENCY]

Information about your provider/supplier agreement and your Medicare enrollment are outlined in the text box below.

Medicare Administrative Contractor Name & Contractor Number	
Medicare Enrollment Determination	
Status	DENIED [OR REVOKED]
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number	

(PTAN)	
Provider/Supplier Agreement Determination	
Provider/Supplier Agreement	DENIED [OR TERMINATED]
CMS Certification Number (CCN)	

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

RECONSIDERATIONS REQUEST—MAILING ADDRESSES:

Requests for Reconsideration: Medicare Provider Enrollment: The reconsideration request regarding your Medicare enrollment may be submitted electronically via e-mail to: ProviderEnrollmentAppeals@cms.hhs.gov or addressed as follows:

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

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

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

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

[If a failed survey was involved, the contractor shall include the following language here: “Note that any survey deficiencies may only be addressed as part of the provider/supplier agreement reconsideration process.”]

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

I. Approval – Voluntary Termination (Part A/B Certified Org)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are voluntarily terminating your provider/supplier agreement **or** [Insert Contractor name [and Contractor number]] has completed processing your application [or

letter] to voluntarily disenroll from the Medicare program. Therefore, your provider agreement has been terminated and your enrollment in the Medicare program has been voluntarily terminated effective on the dates shown below.

Medicare Enrollment and Provider Agreement Information

Medicare Enrollment Termination and Deactivation of Billing Privileges	
Legal Business Name (LBN)	
Doing Business As Name	
Primary Practice Location Address	
Provider/Supplier Type	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)	
Effective Date of Enrollment Termination and Deactivation	

Provider/Supplier Agreement Termination	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.

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

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

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

The rebuttal should be sent to the following:
[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

J. Approval – Reactivation (Part A/B Certified Org)

(This letter should be used for reactivation approvals regardless of whether the application was referred to the state agency for review.)

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and add Contractor number]] has approved your reactivation enrollment application.

Medicare Enrollment Information

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

Provider/Supplier Agreement Specific Information

CMS Certification Number (CCN)	
CCN Effective Date	

Include if applicable: [While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing to fully revalidate during a previous revalidation cycle. You will not be reimbursed for

services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.]

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

- Submit additional information with the reconsideration that may have a bearing on the decision. However, if you have additional information that you would like a Hearing Officer to consider during the reconsideration or, if necessary, an Administrative Law Judge (ALJ) to consider during a hearing, you must submit that information with your request for reconsideration. This is your only opportunity to submit information during

the administrative appeals process unless an ALJ allows additional information to be submitted.

- Include an email address if you want to receive correspondence regarding your appeal via email.

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

And

Requests for Reconsideration: Medicare Provider/Supplier Agreement: For reconsideration of the Provider/Supplier Agreement determination, you must submit a separate Reconsideration Request. Your requests must be e-mailed to:

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

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

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

Sincerely,

[Name]
[Title]
[Company]

(Note: No CC: to State Agency/AO required. Deactivations do not impact certified provider CCN participation status.)

K. Voluntary Termination: Failure to Respond to Request for Information

Month, Day, Year

PROVIDER/SUPPLIER NAME
ADDRESS
CITY, STATE, ZIP

Reference # Application ID

Dear Provider Name (LBN),

[Insert Contractor name [and Contractor number]] has received notification from the State Agency that you are no longer operational. We have not received a response to the request sent on Month DD, YYYY to update your enrollment information. Therefore, we have disenrolled you from the Medicare program. Your [provider/supplier agreement] has also been terminated.

Medicare Enrollment and Provider Agreement Information

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

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

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination. With this termination, your billing privileges are also being deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.

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

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

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

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]

[Contractor Rebuttal Receipt Email Address]

[Contractor Rebuttal Receipt Fax Number]

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

Sincerely,

[Name]

[Title]

[Company]

CC: State Agency [and AO, if applicable]

L. Voluntary Termination Cessation of Business

[Month, Day, Year]

PROVIDER/SUPPLIER NAME

ADDRESS

CITY, STATE, ZIP

Reference Number:

Dear Provider/Supplier Name:

[Insert Contractor name [and Contractor number]] was notified by State Agency Name that on MONTH DD, YYYY, the State Agency attempted to verify if your Type of Provider is operational. The State Agency has reported that your facility was closed, not operational, and/or ceased business at your address of record.

Pursuant to 42 CFR § 489.52(b)(3), CMS considers a cessation of business and providing services to the community to constitute a voluntary withdrawal from the Medicare program.

If you believe that our determination is incorrect and your Type of Provider facility remains operational, you must notify the State Agency and copy this office within 10 days from your receipt of this notice that your facility is still operational and participating in the Medicare program. You must provide the State Agency and this office with information to clarify why your facility was not functional at the address of record at the time the State Agency performed the site survey.

STATE AGENCY NAME

ADDRESS

CITY, STATE, ZIP

We request that you complete and submit a CMS-855 or an application via the Internet-Based Provider Enrollment Chain and Ownership System (PECOS) for a change of information to indicate that your facility/practice location remains open and operational or to request a voluntary termination of your enrollment.

If we do not hear from you, your Medicare enrollment and corresponding Provider Agreement will be terminated pursuant to 42 CFR § 489.52(b)(3). With this termination, your billing privileges will also be deactivated effective on the aforementioned date of the termination pursuant to 42 C.F.R. § 424.540(a)(7).

If you have any questions, please contact our office at:

Sincerely,

[Name]

[Title]

[Company]

M. Approval – Seller CHOW (Part A/B Certified Org)

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

[Insert Contractor name [and Contractor number]] has received notification from the [use “State Agency” or “CMS Survey & Operations Group Location”, as appropriate] that the change of ownership involving [insert seller name] is now approved. Therefore, you have been disenrolled from the Medicare program effective on the date shown below.

Medicare Enrollment Termination Information

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

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

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

N. Federally Qualified Health Centers (FQHCs) – Initial Enrollment Approval Letter

Notwithstanding any other instruction to the contrary in this chapter, the contractor shall use this letter (which was formerly in section 10.7.19 of this chapter) for all FQHC initial enrollment approvals. For all other FQHC transactions (e.g., revalidations), the contractor may use the applicable letters in either 10.7.5 or 10.7.5.1.

[Month, Day, Year]

[FQHC Name]
[Address]
[City, State, Zip]

Reference # (Application Tracking Number)

Dear [FQHC],

[Insert Contractor] has approved your enrollment as a federally qualified health center (FQHC).

Medicare Enrollment Information

Legal Business Name (LBN)	
Doing Business As (DBA)	
Physical Location Address	
National Provider Identifier (NPI)	
Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN)	
PTAN/CCN Effective Date	
Medicare Year-End Cost Report Date	

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

Included with this letter is a copy of your “Attestation Statement for Federal Qualified Health Center” (Exhibit 177), which CMS has signed.

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

Providers and suppliers may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]

[Title]

[Company]

O. Approval – FQHC Change of Ownership

[Month, Day, Year]

[Provider/Supplier Name]

[Address]

[City, State, Zip]

Reference # (Application Tracking Number)

Dear [Provider/Supplier],

Your change of ownership application is now approved. The corresponding executed “Attestation Statement for Federal Qualified Health Center” (Exhibit 177), which CMS has signed, is enclosed/attached. Your enrollment and Exhibit 177 information is outlined below:

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

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

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

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

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

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

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

Right to Submit a Reconsideration Request:

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

Reconsideration requests must:

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

You may:

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

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

The reconsideration request should be sent to:

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

Or emailed to:

ProviderEnrollmentAppeals@cms.hhs.gov

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

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

P. 36-Month Rule Voluntary Termination Letter

[Month, Day, Year]

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

Reference # (Application Tracking Number)

Dear [HHA *or Hospice* Seller],

[Insert Contractor name] has [Insert appropriate situation (e.g., reviewed [insert HHA's current name] change of ownership application; learned that [insert HHA's current name] may have undergone a change in majority ownership pursuant to 42 C.F.R. § 424.550(b)(1); etc.]. After our review, [Insert Contractor name] has determined that [insert HHA's *or hospice's* current name] has undergone a change in majority ownership under 42 C.F.R. § 424.550(b)(1) and that none of the exceptions described in 42 C.F.R. § 424.550(b)(2) apply to this situation. Pursuant to 42 C.F.R. § 424.550(b)(1), therefore, [insert HHA's *or hospice's* current name] provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of [insert HHA's *or hospice's* current name] must instead:

- Enroll in the Medicare program as a new (initial) home health agency under the provisions of 42 C.F.R § 424.510; and
- Obtain a state survey or an accreditation from an approved accreditation organization.

Consistent with the foregoing, [insert HHA's *or hospice's* current name] provider agreement [will be/has been] voluntarily terminated and its Medicare billing privileges [will be/have been] deactivated pursuant to 42 C.F.R § 424.540(a)(8) effective [Insert date(s)].

Medicare Enrollment and Provider Agreement Information

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

Provider/Supplier Agreement Termination	
CMS Certification Number (CCN)	
Effective Date of CCN Termination	
Reason for Termination	

In accordance with 42 CFR § 489.52, Medicare will not reimburse you for any claims with dates of service on or after your effective date of termination.

REBUTTAL RIGHTS:

If you believe that this deactivation determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.

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

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

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

The rebuttal should be sent to the following:

[Contractor Rebuttal Receipt Address]
[Contractor Rebuttal Receipt Email Address]
[Contractor Rebuttal Receipt Fax Number]

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

Sincerely,

[Name]
[Title]
[Company]

CC: State Agency [and AO, if applicable]

Q. Applicable SOG Location E-mail Boxes

CMS Locations Corporate Email Addresses		
CMS LOCATION	BRANCH	EMAIL Address
CMS Boston Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	ACC & LTC	<u>BostonRO-DSC@cms.hhs.gov</u>
CMS Philadelphia Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	ACC & LTC	<u>ROPHIDSC@cms.hhs.gov</u>
CMS New York New Jersey, New York, Puerto Rico, Virgin Islands	ACC & LTC	<u>RONYdsc@cms.hhs.gov</u>
CMS Atlanta Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	ACC & LTC	<u>ROATLHSQ@cms.hhs.gov</u>
CMS Chicago Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	ACC & LTC	<u>ROCHISC@cms.hhs.gov</u>
CMS Kansas City Iowa, Kansas, Missouri, Nebraska	ACC & LTC	<u>ROkcmSCB@cms.hhs.gov</u>
CMS Denver Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	ACC & LTC	<u>DenverMAC@cms.hhs.gov</u>

CMS Dallas

ACC & LTC

RODALDSC@cms.hhs.gov

Arkansas, Louisiana, New Mexico,
Oklahoma, Texas

CMS San Francisco

ACC & LTC

ROSFOSO@cms.hhs.gov

Arizona, California, Hawaii, Nevada, Pacific
Territories

CMS Seattle

ACCB

CMS_RO10_CEB@cms.hhs.gov

v

Alaska, Idaho, Oregon, Washington

LTC

Seattle_LTC@cms.hhs.gov

10.7.12 – Deactivation Model Letter

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

(To be sent by hard-copy mail, and via email if email address is listed in the provider/supplier correspondence mailing address on the enrollment record. Optional to send via fax if a valid fax number is available.)

[Month] [DD], [YYYY]

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

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Medicare billing privileges

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

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

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

DEACTIVATION REASON:

- 42 C.F.R. § 424.540(a)[1-8]

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

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

[Contractor Name] has reviewed your Medicare billing data and found that you have not submitted any claims since January 1, 2017, which is more than 6 calendar months from the date of this letter.)

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

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

REBUTTAL RIGHTS:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.545(b). The rebuttal must be received by this office in writing within 15 calendar days of the date of this letter. The rebuttal must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the rebuttal that you believe may have a bearing on the decision. You must submit all information that you would like to be considered in conjunction with the rebuttal. This includes any application(s) to update your enrollment, if necessary. You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

The rebuttal must be signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative. (Delete next sentence if letter is related to a DMEPOS supplier's enrollment.) [Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned provider/supplier without the provider/supplier submitting a signed statement authorizing that individual from the group to act on his/her/their behalf.]

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

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

Sincerely,

[Name] [Title] [Company]