CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12524	**Date: March 1, 2024**
	Change Request 13449

SUBJECT: Stay of Enrollment

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement 42 Code of Federal Regulations (CFR) Section 424.541, which establishes a new provider enrollment status labeled a "stay of enrollment."

EFFECTIVE DATE: April 1, 2024 - For Business Requirement 13449.6 and Section 10.4.9(D)(2) of Chapter 10.; 90 days from issuance - The MAC shall begin work on all other Business Requirements and provisions once this CR is placed on their contract but implement 90 days from issuance.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 3, 2024 - The MAC shall begin work on all other Business Requirements and provisions once this CR is placed on their contract but implement 90 days from issuance.; 30 days from issuance - For Business Requirement 13449.6 and Section 10.4.9(D)(2) of Chapter 10.

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	10/10.4/10.4.5.1/Revalidation Solicitations
R	10/10.4/10.4.5.2/Non-Responses to Revalidation and Extension Requests
R	10/10.4/10.4.5.3/Receipt and Processing of Revalidation Applications
N	10/10.4/10.4.9/Stay of Enrollment
N	10/10.4/10.4.9.1/Stay of Enrollment Rebuttals
N	10/10.7/10.7.20/Stay of Enrollment Letters

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If

the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 12524	Date: March 1, 2024	Change Request: 13449

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EFFECTIVE DATE: April 1, 2024 - For Business Requirement 13449.6 and Section 10.4.9(D)(2) of Chapter 10.; 90 days from issuance - The MAC shall begin work on all other Business Requirements and provisions once this CR is placed on their contract but implement 90 days from issuance.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 3, 2024 - The MAC shall begin work on all other Business Requirements and provisions once this CR is placed on their contract but implement 90 days from issuance.; 30 days from issuance - For Business Requirement 13449.6 and Section 10.4.9(D)(2) of Chapter 10.

I. GENERAL INFORMATION

A. Background: The Calendar Year 2024 Physician Fee Schedule (PFS) Final Rule (88 Federal Register 78818) contains provisions concerning Medicare provider enrollment. One of these provisions involves the establishment of a new provider enrollment status labeled a "stay of enrollment." This CR updates Chapter 10 of CMS Publication (Pub.) 100-08, Program Integrity Manual, with procedures for implementing the PFS final rule's stay of enrollment provisions.

The contractor is advised that this CR---(1) is not an analysis CR; and (2) only addresses policy matters. System issues will be addressed in a separate CMS directive. Also, additional sections of Chapter 10 of Pub. 100-08 will be updated in a future CR to reflect the stay provisions. The current CR only updates the most pertinent Chapter 10 provisions.

B. Policy: 42 CFR Section 424.541.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13449.1	Unless explicitly instructed to do so either in Chapter 10 of Pub. 100-08 or via another CMS/Provider Enrollment & Oversight Group	X	X	X						NPEAST, NPWEST

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(PEOG) directive, the contractor shall not--(i) initiate or impose a stay; or (ii) refer a potential stay case to PEOG if the contractor believes a certain situation it has encountered may warrant one.									
13449.2	The contractor shall become familiar with the stay of enrollment policies and regulatory provisions outlined in sections 10.4.9(A) through (C) in Chapter 10 of CMS Pub. 100-08.	X	X	X						NPEAST, NPWEST
13449.3	The contractor shall abide by the instructions in Sections 10.4.9(D), (E), (F), and (G) concerning stays of enrollment, including use of the letters in Section	X	X	X						NPEAST, NPWEST

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	10.7.20.									
13449.4	The National Provider Enrollment (NPE) contractors (NPE East and NPE West) and the Durable Medical Equipment Medicare Administrative Contractors DME MACs shall interact, coordinate, and communicate with each other in stay situations consistent with CMS instructions and in instances generally akin to those involving deactivations.				X					NPEAST, NPWEST
13449.5	The contractor shall follow the instructions in Section 10.4.9.1 in Chapter 10 of Pub. 100-08 concerning stay of enrollment rebuttals.	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13449.6	The contractor shall observe that the effective and implementation date for Section 10.4.9(D)(2) in Chapter 10 of Pub. 100-08 is 30 days from issuance. (All other business requirements and provisions in this CR have an effective and implementation date of 90 days from issuance.)	X	X	X	X					NPEAST, NPWEST

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13449.7	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with	X	X	X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	your local educational content after we release the newsletter.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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.12524; Issued: 03-01-24)

10.4.5.1 – Revalidation Solicitations

(Rev.12524; Issued: 03-01-24; Effective: 04-01-24; Implementation: 06-03-24)

A. Background

Under previous practice, CMS identified the providers and suppliers required to revalidate during each cycle. CMS communicated when new lists became available through the appropriate channels, at which time the contractor obtained the list from the CGI Share Point Ensemble website. With the advent of PECOS 2.0, PECOS will automatically: (i) determine when a provider/supplier is due to periodically revalidate its enrollment; and (ii) send a revalidation notice to the provider/supplier. Note that this new process of revalidation solicitation applies both to providers/suppliers that currently submit applications via (or otherwise utilize) PECOS or via paper. For the former group, solicitations will be sent via the PCV. For the latter, solicitations will be e-mailed via PECOS, and the affected provider/supplier may submit its revalidation application via paper; it is not required to use PECOS.

B. Sending Revalidation Letters

Based on the due date identified in PECOS, PECOS will send a revalidation notice (using the applicable letter in section 10.7 et seq. of this chapter) between 90 to 105 days prior to the provider/supplier's revalidation due date. The initial revalidation letter will include a generic provider enrollment signature.

C. Interaction with Change Request

If the contractor receives a change of information (COI) application from the provider after PECOS has mailed to the provider a revalidation notice, the contractor shall process it as a COI with no merger of the two applications; the applications shall be processed separately.

If the provider submits an application marked as a revalidation but that only includes enough information to be considered a COI, the contractor shall (1) develop for a complete application containing the missing data elements and (2) treat it as a revalidation.

D. Interaction with a Change of Ownership (CHOW)

PECOS will not commence revalidation action regarding a provider/supplier that is undergoing a CHOW that: (1) the contractor is currently processing; or (2) is pending review with the state agency.

E. Reassignment Applications Received After Revalidation Letter Mailed

If a reassignment application has been received after a revalidation letter has been sent to the affected provider/supplier, the contractor shall process the reassignment application. The supplier need not report the newly established reassignment/employment arrangement on the revalidation application, and the contractor shall not develop for this information; this is because the arrangement was established after the revalidation notice was issued. However, the contractor shall maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application; this information shall not be overridden. If the supplier fails to respond to the revalidation request, all reassignments shall be end-dated, including the newly established reassignment. Consider the following illustration:

EXAMPLE: Dr. Doe submits a reassignment application to add a new reassignment to Browns Medical Center after receiving a revalidation request. He submits his revalidation

application to his contractor but does not include the reassignment for Browns Medical Center because the contractor is still processing the reassignment application and has not yet approved the reassignment. The contractor finalizes the reassignment changes and then proceeds with processing the revalidation application. The contractor shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

F. Revalidation Extension Requests

The contractor shall only accept extension requests from a provider that was not given the full 7 months' advance notice prior to their revalidation due date. The contractor shall not accept extension requests from providers for any other reason.

The provider/supplier may submit its request in writing (fax/e-mail/PCV permissible) or via phone, though the individual provider, authorized/delegated official, or appropriate contact person shall make the request. (See section 10.3 of this chapter for information regarding contact persons for PECOS applications.)

G. Additional Letter Data

In addition to the PCV e-mailing revalidation correspondence, the contractor – in any circumstance required per this chapter -- shall print and mail the following PCV-generated letters: (1) revalidation notification letters (e.g., the first letter came back as undeliverable (see subsection (B)(2) above)); (2) *stay of enrollment* letters; and (3) deactivation letters.

(NOTE: As a general rule, the PCV can, among other things: (1) automatically send emails (e.g., revalidation); (2) send e-mails upon request (e.g., development); (3) generate letters/store letters; (4) send letters to a print queue; and (5) accept document uploads,)

10.4.5.2 – Non-Responses to Revalidation and Extension Requests

(Rev.12524; Issued: 03-01-24; Effective: 04-01-24; Implementation: 06-03-24)

A. Phone Calls

The contractor may (but is not required to) continue to contact providers via telephone or e-mail to communicate non-receipt of revalidation applications.

B. *Stay of Enrollment and Non-Responses to Revalidation Requests*

(The contractor shall follow existing guidance regarding the application of stays of enrollment in revalidation situations, including that in section 10.4.9(D) of this chapter.)

No later than 5 business days after sending the applicable deactivation letter *per existing guidance* -- and if the deactivated supplier is a physician – the contractor shall search his/her associate record to determine if he/she serves as a supervising physician on any independent diagnostic testing facility (IDTF) enrollment. If he/she does, the contractor shall disassociate him/her as the supervising physician for that entity. If he/she is the only supervising physician n file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

10.4.5.3 – Receipt and Processing of Revalidation Applications

(Rev.12524; Issued: 03-01-24; Effective: 04-01-24; Implementation: 06-03-24)

The provider may submit its revalidation application via paper or PECOS, though the latter is encouraged to allow for more expedited processing.

For paper applications, the contractor shall input the relevant data in PECOS consistent with longstanding practice and with the policies in this chapter, including those in section 10.3.

Note that some of the instructions in this section 10.4.5.3 et seq. may be inapplicable to PECOS (e.g., developing for missing sections of the Form CMS-855 revalidation application). *Also, the stay of enrollment instructions in sections 10.4.5.2 and 10.4.9 take precedence over those in this section 10.4.5.3 in the event of any conflict.*

A. General Situations

1. Unsolicited Applications

An unsolicited revalidation application is one received outside of the PECOS revalidation request addressed in section 10.4.5.1. The contractor shall return such applications using the applicable sample return letter in section 10.7 et seq. within 20 business days of receipt. If the application was received more than 7 months prior to the provider/supplier's revalidation due date, the contractor shall use § 424.526(a)(8) as the return basis. If § 424.526(a)(8) does not apply to the situation, the contractor shall use § 424.526(a)(7) as the basis, for the application was inapplicable to or not needed for the transaction involved.

If applicable, the contractor shall also submit a request to CMS to have the application fee returned to the provider.

2. Signatures

The contractor may only accept revalidation applications signed by the individual provider or the authorized or delegated official.

3. Sub-Units

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

4. Collapse of PTANs

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

5. Voluntary Withdrawal

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

If a non-certified supplier wishes to voluntarily withdraw from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail, or fax from the individual supplier or the authorized/delegated official (on letterhead); the contractor shall not require the non-certified supplier to complete a Form CMS-855 or CMS-

20134 application. If the contractor makes the request via telephone, the contractor shall document the telephone conversation in PECOS and take the appropriate action in PECOS.

B. Development Required

(Note that some of the instructions in this subsection (B) will be inapplicable to PECOS applications. See section 10.3 for more information.)

1. General Instructions

If a revalidation application requires development (e.g., missing application fee, clarification or documentation needed, missing reassignments), the contractor shall notify the provider via mail, telephone, the PCV, fax, or e-mail. The contractor shall develop for all of the required information in one development request. The provider has 30 days to respond to the contractor's request. For paper applications, the provider may submit the information via mail, fax, or e-mail containing scanned documentation; this includes missing signatures and dates. For PECOS applications, the provider must submit the information via PECOS. (Note that the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report missing reassignments any time prior to their revalidation due date; this includes post-revalidation application approval.)

If the contractor can verify licensure and/or educational requirements (e.g., non-physician practitioner's degree or diploma) online, the contractor shall not require the provider to submit this documentation. If the supporting documentation currently exists in the provider's file, the provider need not submit that documentation again with their revalidation application; the contractor may utilize the existing documentation for verification. Residency information is not required as part of a revalidation. In addition, the contractor need not develop for data that is missing or needs clarification on the provider's revalidation application if the provider accurately disclosed (meaning no clarification is needed) the information (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, though with the exception of the following items:

(i) Adverse legal action data
(ii) LBN
(iii) Tax identification number (TIN)
(iv) NPI-legacy number combinations
(v) Supplier/Practitioner type
(vi) DBA name
(vii) Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

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

The contractor shall not develop for the EFT form if the provider has the 05/10 or 09/13 version of the Form CMS-588 on file. If provider submits an EFT form with a bank letter or voided check, the contractor may verify that the LBN matches and develop to process the application accordingly. Note that the instructions in section 10.6.23 apply to revalidations.

If the supporting documentation currently exists in the provider's file, the provider need not submit that documentation again during the enrollment process. The contractor shall utilize the existing documentation for verification. Documentation submitted with a previously

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

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

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

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

2. Illustrations

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

SCENARIO #1 - PECOS issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application but only addresses the reassignment for Group A. The contractor develops with the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application remains in progress, the provider may submit a full Form CMS-855I or Sections 1, 2, 4, & 15 of the Form CMS-855I to report the missing reassignment information (even post-revalidation application approval). Here, the contractor processes the revalidation application to completion, and the provider experiences no break in billing.

SCENARIO #2 - The contractor issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the contractor but only addresses the reassignment for Group A. The contractor develops with the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days, and the revalidation due date has passed. In this situation, Group A's reassignment is revalidated, and the contractor shall deactivate Group B & C's reassignments and/or employment arrangements effective with the date on which the contractor took deactivation action due to non-response or incomplete response to a development request. The approval letter shall identify the reassignments and/or employment arrangements that were revalidated and those that were terminated with the effective date of the reassignment or termination. The provider

must submit a full application (Form CMS-855R) to reactivate the reassignment. The reactivation effective date is based on the receipt date of the CMS-855R.

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

Contractor-initiated development letters, however, shall include a provider enrollment analyst's name and phone number for provider contacts.

C. Revalidation Received After a Deactivation Occurs

1. General Guidance

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

2. Certified Providers and Certified Suppliers

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

D. Finalizing the Revalidation Application

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

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

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

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

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

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

(vi) Ensure that an enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs but not all PTANs have been addressed (meaning that

no action has been taken on the non-response PTANs, e.g., end-dated). If all PTANs have been addressed (e.g., revalidated, end-dated), the enrollment can be marked as revalidated.

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

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

E. Revalidation Reporting

Unless CMS requests it, the contractor need no longer submit reports to CMS regarding its revalidation activities, for the revalidation data is captured in PECOS.

10.4.9 – Stay of Enrollment
(Rev.12524; Issued: 03-01-24; Effective: 04-01-24; Implementation: 06-03-24)

(In the event of any inconsistency between the instructions in this section 10.4.9 and other instructions in chapter 10, the 10.4.9 instructions take precedence if a stay of enrollment situation is involved.)

A. Background

In the Calendar Year 2024 Physician Fee Schedule final rule (CMS-1784-F), CMS established a new provider enrollment status in 42 CFR § 424.541 labeled a "stay of enrollment." The purpose was to create a CMS action that would be less burdensome on providers/suppliers (hereafter collectively "provider," except as otherwise noted) than a deactivation or revocation. It represents a middle ground between (1) a deactivation and (2) non-action on CMS' part. It gives CMS greater flexibility to take appropriate, fair, and reasonable measures commensurate with the degree of the provider's non-compliance.

A stay of enrollment (or simply "stay") is a preliminary, interim status---prior to any subsequent deactivation or revocation---that would represent, in a sense, a "pause" in enrollment, during which the provider would nonetheless remain enrolled in Medicare. In this vein, CMS would neither formally nor informally treat the stay as a sanction or adverse action for purposes of Medicare enrollment.

Unless CMS explicitly instructs the contractor to do so (such as per section 10.4.9(D) below), the contractor shall not: (i) initiate or impose a stay; or (ii) refer a potential stay case to PEOG if the contractor believes a certain situation it has encountered may warrant one.

B. Regulatory Requirements for Imposition -- Two-Step Test under § 424.541(a)(1)

As outlined in § 424.541(a)(1)(i) and (ii), there are two requirements for a stay's implementation. Specifically, the provider:

- *Is non-compliant with at least one enrollment requirement in Title 42; **and***

- *Can remedy the non-compliance via the submission of, as applicable to the situation, a Form CMS-855, Form CMS-20134, or Form CMS-588 change of information or revalidation application (hereafter occasionally and collectively referenced as "the applicable CMS form" or "ACF".)*

Examples of how this bright-line, two-pronged test would be met include:

- *A provider failed to timely report a change in its address from 10 Smith Street to 20 Smith Street.*
- *A supplier did not respond to a revalidation request.*
- *A DMEPOS supplier did not report the deletion of a managing employee.*
- *A physician did not timely report a change in his/her practice location's zip code.*
- *An MDPP supplier failed to timely report a change in the address of an organizational owner.*
- *An IDTF failed to comply with a supplier standard in § 410.33(g) but compliance can be reached by submitting an ACF.*

In these illustrations, the provider failed to adhere to a reporting, revalidation, or supplier standard requirement in Title 42 (the first prong of the § 424.541(a)(1) test) but could resume compliance by submitting the applicable CMS form (the second prong). (It is important to understand that if the type of non-compliance involved cannot be corrected via the submission of an ACF, a stay cannot be imposed.) These are merely examples, however, and there are many scenarios in which a stay could apply.

Examples of when the stay of enrollment test would not be met include:

- *A provider's owner has been convicted of a felony.*
- *A physician has lost his/her state medical license.*

Although the first prong of the § 424.541(a)(1) test --- non-compliance --- has been met in these situations, the provider cannot correct the non-compliance simply by submitting an ACF.

C. Important Facets of a Stay as Outlined in § 424.541

Section 424.541 also contains the following provisions:

1. Enrollment Status (§ 424.541(a)(2)(i)) – As previously mentioned, the provider remains enrolled in Medicare during the stay.

2. Claims (§ 424.541(a)(2)(ii)):

Per § 424.541(a)(2)(ii)(A) – and except as stated in § 424.541(a)(2)(ii)(B) -- claims submitted by the provider with dates of service within the stay period will be rejected.

Under § 424.541(a)(2)(ii)(B), claims submitted by the provider with dates of service within the stay period are eligible for payment (assuming all other requirements for claim payment are met) if:

- *CMS or its contractor determines that the provider has resumed compliance with all Medicare enrollment requirements in Title 42 (§ 424.541(a)(2)(ii)(B)(1)); and*
- *The stay ends before its original expiration date. (To illustrate, suppose CMS imposes a stay period of 30 days. The claims described in § 424.541(a)(2)(ii)(B) would be payable if the provider resumes compliance on or before the 30th day of the stay.)*

To reiterate, the requirements of both § 424.541(a)(2)(ii)(B)(1) and (2) must be met for payments to be made pursuant to § 424.541(a)(2)(ii)(B).

3. Maximum Duration of the Stay (§ 424.541(a)(3)) - A stay of enrollment lasts no longer than 60 days from the postmark date of the notification letter, which is the effective date of the stay. ***For purposes of this requirement, the postmark date is the date on which the letter is mailed. For instance, suppose the letter is mailed on June 1. The stay period commences on June 1, which is also the stay's effective date.***

Again, a stay has a maximum length of 60 days and cannot be extended. Note, however, that CMS can impose a stay of less than 60 days. It is not required that each assigned stay period be 60 days.

4. End-Date of the Stay (§ 424.541(a)(5)) – A stay ends on the earlier of the following dates:

- *The date on which CMS or its contractor determines that the provider has resumed compliance with all Medicare enrollment requirements in Title 42, OR*
- *The day after the imposed stay period expires.*

For purposes of § 424.541(a)(5) ONLY:

++ The term "has resumed compliance" means the provider has submitted the ACF that CMS requested the provider to submit in the stay notification letter*. (See section 10.4.9(C)(5)(f) below for more information.) To illustrate, assume a provider receives a stay notification letter on March 1 because the provider had failed to timely report an address change via the Form CMS-855B. The letter requests the provider to submit this ACF. The provider does so on March 10. The stay thus ends on March 10. Note that the contractor need not have begun processing the ACF for a stay to be lifted. Even if the application is later returned, rejected, or denied, the stay ceases on the date the application is submitted.*

++ For paper ACFs, the ACF is considered "submitted" on the date the contractor receives the ACF (e.g., in its mailroom).

5. Additional Considerations

a. Adverse Action - A stay is not considered an adverse legal action of any kind.

b. Deactivations and Revocations - ***CMS always reserves the right to impose:***

(i) ***A deactivation or revocation instead of a stay, even in cases of minor non-compliance. It should not be assumed that a stay will always be the first step in such situations****.*

(ii) ***A deactivation prior to the expiration of the stay, in which case the deactivation ends the stay***

c. Multiple Stays and Extensions – CMS will neither extend a stay period beyond 60 days nor apply a subsequent stay based on the same non-compliance (e.g., the provider failed to reach compliance within the imposed/assigned stay period (e.g., within 15 days), so CMS immediately applies another stay). Yet CMS may impose a stay multiple times against the provider for separate instances of non-compliance (e.g., one stay in June 2024, another stay in December 2025, and so forth).

d. Timeliness – Normal timeliness standards (as outlined in section 10.5 of this chapter) and processing alternatives (outlined in chapter 10) apply when the contractor is processing the ACF.

e. Applicable Forms and Transactions – As stated in § 424.541(a)(1), the types of ACFs for stay purposes are the Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855S, Form CMS-20134, Form CMS-855O (though the CMS-855O will not involve claim submissions, retroactive payments, etc.), and Form CMS-588. The applicable transactions are limited to changes of information and revalidations. For purposes of the stay, however, the term "changes of information" can include, at CMS' discretion, reassignment situations under the Form CMS-855I.

f. Compliance – Except as stated or instructed otherwise by CMS, and strictly and solely for purposes of lifting/ending a stay, compliance under §§ 424.541(a)(2)(ii)(B)(1) and (a)(5) is reached when the provider submits the ACF. ***Once the stay expires, though, compliance under Title 42 is only resumed consistent with existing policies (e.g., the contractor approves the change of information).***

g. Ordering/Certifying – A stay has no effect on a physician/practitioner's ability to order/certify/refer/prescribe services, items, or drugs.

h. Stay Periods – Except as instructed otherwise by CMS, all assigned stay periods for revalidation non-responses (see subsection (D)(1) below) will be 30 days (rather than 60 days). For the PEOG-directed stays described in subsection (D)(2) below, PEOG will notify the contractor of the assigned stay period for that specific case.

6. General Stay Process for Revalidations

In general – and subject to the more specific scenarios described in section 10.4.9(D)(1) -- the stay process will work as follows in situations where the provider fails to submit a revalidation application in response to a CMS/contractor revalidation request:

Implementing the Stay *- Within 10 days after the expiration of the period in which the provider had to submit the revalidation application, the contractor shall: (a) send to the provider via regular mail the letter identified in section 10.7.20(A); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed.*

Removing the Stay if the Provider Submits the Revalidation Application During the Stay *- Within 10 days after the revalidation application is submitted, the contractor shall change the PECOS status to "Approved – Remove Stay of Enrollment."*

Failure to Respond During the Allotted Timeframe *– Within 10 days of the allotted timeframe described below, the contractor shall deactivate the provider in accordance with CMS directives.*

(This also includes the contractor turning on and turning off claim rejection edits as warranted (e.g., implementing the edits when the stay is imposed).)

Note that the above general process will be largely similar in cases where CMS directs the contractor to impose a stay in a specific case, the principal exception being the timeframe for contractor action in certain situations. These cases are addressed in subsections (D)(2)(a) through (D)(2)(c) below.

D. Case Studies

This section 10.4.9(D) contains more detailed scenarios addressing how the stay process will typically operate and the contractor's required activities therein. (Except as otherwise indicated, all days are calendar days.)

1. Non-Response to Revalidation Request

These scenarios assume the provider (Smith Health Care) failed to submit the requested revalidation application within the required revalidation timeframe (RRT) – the last day of which, for purposes of our examples, is February 27.

Scenario A – Revalidation Application Submitted During Stay Period and Is Approved

Step 1 –No later than 10 days after the expiration of the RRT, the contractor shall: (a) send to Smith via regular mail the letter identified in section 10.7.20(A); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed. Thus, if the letter is mailed March 5, the PECOS status should be changed effective March 5, which will be the effective date of the stay. This means Smith has until April 4 (or 30 days) to submit the revalidation application. Claims for services furnished beginning March 5 to the end of the stay will be rejected except as stated in § 424.541(a)(2)(ii)(B).

(If the contractor receives the revalidation application from Smith after the RRT expires but before it mails the stay notification letter, the contractor can process the application as normal without imposing a stay.)

Step 2 – Smith submits the revalidation application on March 16.

Step 3 – No later than 10 days after the revalidation application is submitted, the contractor shall change the PECOS status to "Approved – Remove Stay of Enrollment" effective on the submission date (March 16 if the application was submitted via PECOS). Claims for services furnished between March 5 and March 16 (i.e., the duration of the stay) are therefore payable.

Step 4 – The contractor processes the revalidation application to approval and takes all standard actions related thereto (e.g., sends approval letter, switches PECOS record to "Approved"). No further action needed.

Scenario B – Revalidation Application Not Submitted at All

Assume that Step 1 is the same as Step 1 in Scenario A.

Step 2 – Smith fails to submit the revalidation application by April 4, the last day of the stay period. The contractor need take no action regarding the lifting of the stay (e.g., notifying the provider of the stay's cessation).

Step 3 – Within 10 days of the April 4 date (i.e., by April 14), the contractor shall: (a) change the PECOS status to "Deactivated" effective the day after the RRT expired (or February 28); and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).

Note that the deactivation effective date is retroactive to the date of the non-compliance (again, February 28), or the date by which Smith was required to submit the revalidation application to CMS. This means that even though the stay was lifted effective April 5 and claims furnished on or after that date are thus payable, this will effectively be negated by the retroactive deactivation in a manner akin to how retroactive deactivations currently operate.

Due to the provider's failure to submit the application during the stay period, claims for services furnished during the stay (March 5 – April 4) are not payable.

Scenario C – Revalidation Application Submitted During the Stay but Is Rejected

Assume Steps 1, 2, and 3 are the same as Steps 1, 2, and 3 in Scenario A.

Step 4 – The contractor determines that the revalidation application should be rejected.

Step 5 – The contractor shall:

- *Process the rejection consistent with existing procedures.*
- *Within 10 days of sending the rejection letter, the contractor shall: (a) change the PECOS status to "Deactivated" effective the day after the RRT expired (or February 28); and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).*

Scenario D – Revalidation Application Not Submitted During the Stay but Is Submitted After the Stay Period Expires

Assume Step 1 is the same as Step 1 in Scenario A. (Note that the stay expired on April 4.)

Step 2 - Smith submits the revalidation application on April 7.
Step 3

Step 3A - If the contractor receives the revalidation application before it mails the deactivation letter (as described in Step 3 of Scenario B), the contractor can process the application as normal without imposing a deactivation.

Step 3B – If the contractor receives the revalidation application after it mails the deactivation letter, it shall process the application as a reactivation application.

2. PEOG-Directed Stays

The situations in this subsection (D)(2) only apply when PEOG directs the contractor via e-mail to impose a stay. Except as otherwise instructed, the contractor need not notify PEOG that it has imposed the stay, whether the provider submitted the ACF, whether and when a deactivation was imposed, etc.

a. Ownership Discrepancies

PEOG may notify the contractor via e-mail to apply a stay against a particular provider due to incorrect enrollment information pertaining to ownership; the provider must correct this data by submitting an ACF. In such cases, the contractor shall follow the general stay procedures, steps, and scenarios outlined in subsection (D)(1) above except as follows:

- *Step 1 of Scenarios A, B, C, and D - Within **5** days of receiving this e-mail, the contractor shall: (a) send to the provider via regular mail the letter identified in section 10.7.20(B); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed.*

- *Step 3 of Scenarios B and D - Within **5** days after the expiration of the 30-day stay period, the contractor shall: (a) change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).*

- *Step 5 of Scenario C - Within **5** days of sending the rejection letter, the contractor shall: (a) change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).*

- *Step 3B of Scenario D - If the contractor receives the ACF after it mails the deactivation letter, it shall request the submission of or develop for a reactivation application.*

To illustrate the first three exceptions, suppose the contractor receives an e-mail from PEOG on August 1 directing it to impose a stay on Provider X because X's ownership data is incorrect. If this were a revalidation situation, the contractor would have 10 days (or until August 11) to complete Step 1. Here, however, the contractor must complete Step 1 by August 6.

Now assume the contractor finishes Step 1 on August 4. The stay begins that day and ends on September 3. Provider X fails to submit the ACF during that period. The contractor must complete Step 3 by September 8 (rather than September 13). If X timely submitted the ACF but the contractor rejects it and sends the rejection letter on September 20, the contractor must complete Step 5 of Scenario C by September 25.

In sum, the only material differences between the general procedures in subsections (D)(1) and (D)(2)(a) are:

- *The timeframes for contractor action (10 days vs. 5 days)*
- *(D)(1) addresses revalidations --- for which no prior notification from PEOG is needed to impose a stay --- whereas (D)(2)(a) applies only to ownership discrepancies and requires said notification from PEOG.*
- *In (D)(1) cases, any deactivation effective date is retroactive to the day after the RRT's expiration. For (D)(2)(a) situations, the deactivation effective date is retroactive to the date of the stay notification letter.*

b. Immediate Imposition

Situations could occur when PEOG directs the contractor via e-mail to immediately impose a stay. Here, and except if PEOG directs otherwise:

- *Step 1 of Scenarios A, B, C, and D - Within **1 business day** of receiving this e-mail, the contractor shall: (a) send to the provider via regular mail the letter identified in section 10.7.20(B); and (b) switch the PECOS status to "Approved – Stay of Enrollment" effective the date the letter is mailed.*

- *Step 3 of Scenarios B and D - Within **1 business day** after the expiration of the 30-day stay period, the contractor shall -- (a) Change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) Take all other measures normally associated with a deactivation (e.g., send deactivation letter).*

- *Step 5 of Scenario C - Within **1 business day** of sending the rejection letter, the contractor shall: (a) change the PECOS status to "Deactivated" effective the date the stay notification letter was mailed; and (b) take all other measures normally associated with a deactivation (e.g., send deactivation letter).*

- *Step 3B of Scenario D - If the contractor receives the ACF after it mails the deactivation letter, it shall request the submission of or develop for a reactivation application.*

Aside from the above timeframes, the contractor shall follow the general procedures, steps, and scenarios outlined in subsection (D)(1) above.

c. All Other PEOG-Directed Stays

For all PEOG-directed stays other than those described in subsections (D)(2)(a) and (b), the following apply:

- *As with revalidations, the contractor has 10 days to undertake the actions described in Steps 1, 3 (Scenarios B and D), and 5 (Scenario C).*

- *Step 3B of Scenario D - If the contractor receives the ACF after it mails the deactivation letter, it shall request the submission of or develop for a reactivation application.*

E. Other Scenarios

The contractor may encounter stay situations not explicitly identified in subsection (D) above. In such situations, the contractor shall -- to the maximum extent possible -- still follow the general processes and basic steps outlined in the (D)(1) and (2) scenario(s) most applicable to the case the contractor is handling. If the contractor nonetheless needs additional guidance, it shall contact its PEOG BFL for guidance.

F. Letters

The contractor shall send all stay notification letters 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.***

G. Rebuttals

See section 10.4.9.1 of this chapter for information concerning rebuttals of stays of enrollment.

H. NPE and DME MAC Interaction

The NPEs and the DME MACs shall interact, coordinate, and communicate with each other in stay situations consistent with CMS instructions and in instances generally akin to those involving deactivations. This could include, for example:

- *The NPE notifying the applicable DME MAC of the imposition or lifting of a stay and any subsequent deactivation.*
- *Upon being informed of a stay by the NPE, the DME MAC holding payment for services furnished during the stay period.*

10.4.9.1 – Stay of Enrollment Rebuttals

(Rev.12524; Issued: 03- 01-24; Effective: 04-01-24; Implementation: 06-03-24)

Note that the MAC will handle all non-DMEPOS supplier stay rebuttals consistent with the instructions in this section 10.4.9.1 and all other CMS guidance. DMEPOS supplier stay rebuttals will be handled by the PEOG appeals and rebuttals contractor.

A. Background

Pursuant to 42 CFR § 424.541(b), a provider/supplier (hereafter "provider") under a stay of enrollment may file a rebuttal. A rebuttal is an opportunity for the provider to demonstrate that it met all applicable enrollment requirements and that the stay should not have been imposed. Only one rebuttal request may be submitted per enrollment stay. Additional rebuttal requests submitted for the same stay for which a rebuttal has already been received shall be dismissed.

If the applicable CMS form (ACF) (see section 10.4.9) is received for a "stayed" provider while a rebuttal submission is pending or during the rebuttal submission timeframe, the contractor shall process the ACF consistent with current instructions.

B. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Pursuant to 42 C.F.R. § 424.541(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 disagrees, and the reasons for disagreement;

(3) Include all documentation the provider wants CMS to consider in its review of the stay;

(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 stay notification letter to the provider. 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 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. (The contractor can use the same rebuttal dismissal letters applicable to deactivation letters, modifying them to apply to the stay situation.) For those rebuttal submissions that are improperly signed and/or do not specify the facts or issues with which the provider disagrees and the reasons for disagreement, the contractor shall send a development request via hard-copy mail, email, if available, to the provider requesting a proper signature and/or clarification on the facts or issues with which the provider 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 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 control that prevented the timely submission of a rebuttal. These uncontrollable circumstances do not include the provider'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 of the stay notification letter 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 responsibility to timely update their enrollment record to reflect any changes to their enrollment information including, but not limited to, their correspondence address. Failure to timely update a correspondence address or other addresses included in their Medicare enrollment record does not constitute an "in fact" showing that the stay 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 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, 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 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 submits a written request to withdraw its rebuttal submission prior to the issuance of a rebuttal determination, the contractor shall issue a letter using the applicable rebuttal withdrawn model letter and no rebuttal determination shall be issued.

All materials received from the provider shall be considered by the contractor in its review.

4. Reason-Specific Instructions

i. General

As explained in section 10.4.9, CMS may impose a stay if the following two requirements are met:

- *The provider is non-compliant with at least one enrollment requirement in Title 42;* ***and***
- *The provider can remedy the non-compliance via the submission of, as applicable to the situation, a Form CMS-855, Form CMS-20134, or Form CMS-588 change of information or revalidation application (hereafter collectively referenced as "the applicable CMS form" or "ACF".)*

In its review, therefore, the contractor shall, as a general principle, ascertain whether the provider (1) was indeed non-compliant and (2) can remedy the non-compliance by submitting an ACF. The contractor can review section 10.4.8.1(C)(4) (which addresses deactivation rebuttals) and apply the same basic principles discussed in those illustrations to their factually corresponding stay rebuttal situations.

Note that for stay rebuttals other than that discussed in Example (ii)(A) below, the contractor may need additional information (beyond that referenced in section 10.4.9(A)) regarding PEOG's decision to impose a stay. In such cases, the contractor shall contact ProviderEnrollmentRevocations@cms.hhs.gov and clearly outline the requested data. The 30-day timeframe for processing the rebuttal stops between the times the contractor sends the request and receives the information from PEOG.

C. Determination

The contractor shall render a determination regarding a rebuttal submission using the appropriate model rebuttal decision letter. If the contractor is unable to render a determination, the contactor shall use the appropriate model letter for the specific situation. All determinations (including dismissals and withdrawals) related to rebuttal submissions shall be sent (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, it shall make the necessary modification(s) to the provider's enrollment within 5 calendar days of the date of the favorable determination letter. This will involve a rescission of the stay regardless of whether the stay has already been lifted or is still in effect. If the contractor confirms that the ACF 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 in section 10.7.7 of this chapter: "A rebuttal decision has been issued; therefore, the submitted Form CMS [855/588/20134] is not needed." If new changes were being reported as part of the ACF, the contractor shall process those changes.

If the contactor issues a rebuttal determination unfavorable to the provider or supplier, the stay (irrespective of whether it has been lifted) remains intact. Hence, if a stay existed from March 1 to March 10 and the stay was upheld on April 1, the record shall still reflect that the provider was under a stay between March 1 – 10.

D. No Further Review

Pursuant to § 424.541(b)(6), a determination made regarding a stay 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.

E. External Monthly Reporting for Stay Rebuttals

(This data shall be reported in a template separate from that concerning deactivation rebuttals per section 10.4.8.1.)

Using the provider enrollment rebuttals reporting template, the contractor shall complete all columns listed for all stay rebuttal submissions received and processed by the contractor. No column shall be left blank (except Column K, as described below and as applicable). 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*
    - *Palmetto JJ*
    - *Palmetto JM*
    - *WPS J5*
    - *WPS J8*

- ***Column F:*** *The contractor shall briefly describe the non-compliance that led to the stay (e.g., revalidation non-response).*

- ***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 stay has been resolved (e.g., CMS rescinded the stay).*
    - ***Favorable:*** *(to provider/supplier) Contractor has determined that an error was made in the implementation of the stay. Therefore, the initial determination was overturned and the stay has been rescinded.*
    - ***Unfavorable:*** *(to provider/supplier) Contractor upholds the initial stay*

determination.

- ***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 acknowledged 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 stay, 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.*

10.7.20 – Stay of Enrollment Letters

(Rev.:12524; Issued: 03-01-24; Effective: 04-01-24; Implementation: 06-03-24)

This section 10.7.20 contains letters that contractors shall use in stay of enrollment situations. Note that the contractor may remove language from the letter that obviously does not apply to the provider/supplier type in question (e.g., reassignment language in a letter pertaining to an HHA under a stay).

A. Imposition of Stay of Enrollment Notification Letter – Revalidation Non-Response

Stay of Enrollment

[month] [day], [year]

[Provider/Supplier
Name] [Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Pursuant to 42 CFR § 424.541, we are placing a stay on your Medicare enrollment record effective [insert day of letter's issuance] because you have not responded to our revalidation request of [date revalidation request letter sent]. Your revalidation was due on [inset date].

During this stay, claims for services and items you furnish during this period will be rejected. H o w e v e r , this does not affect your Medicare participation agreement or any of its conditions, and you remain enrolled in the Medicare program.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. Failure to submit a revalidation application within 30 days of this notice may result in a deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

*[Name] | **NPI** [NPI] | **PTAN** [PTAN]*

Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

The CMS lists the records that need revalidating at:

***go.cms.gov/MedicareRevalidation**.*

How to resume your payments:

- ***Revalidate your Medicare enrollment record**, through https://pecos.cms.hhs.gov/pecos/login.do or [Form CMS-855 or Form CMS-20134].*

- ***Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484- 8049.*
- ***Paper:** Download the right version of [form CMS-855 or Form CMS-20134] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the stay of enrollment as indicated in 42 C.F.R. § 424.541(b). The rebuttal must be received 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 stay 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.) 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 who 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's or supplier's behalf. The notice should be signed by the provider/supplier.

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

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

The provider's or supplier's failure to submit a rebuttal that is both timely and fully compliant with all of the requirements above constitutes a waiver of all rebuttal rights. The rebuttal should be sent to the following:

[For non-DMEPOS:

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

OR, as applicable

Name and address of MAC

For DMEPOS:

Chags Health Information Technology LLC
P.O. Box 45266 Jacksonville, FL 32232]

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

If you need help

*Visit **go.cms.gov/MedicareRevalidation***

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]

[Company]

B. Imposition of Stay Notification Letter – All Situations Other than Section 10.7.20(A)

Stay of Enrollment

[month] [day], [year]

[Provider/Supplier
Name] [Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Pursuant to 42 CFR § 424.541, we are placing a stay on your Medicare enrollment record effective [day of letter's issuance] because [provide explanation, such as "you did not

report a new managing employee within 30 days of the change as required under 42 CFR § 424.516 (or 42 CFR § 424.57(c)(2) for DMEPOS suppliers)" or "your current ownership information on file with Medicare is incorrect"].

> *[Example of supporting facts and rationale: [ABC, Inc.'s Medicare 855 enrollment record reflects that Jane Doe is the owner, authorized official, director and managing employee of Argo Medical Supplies & Services, Inc. However, CMS has found information on the New York Secretary of State which reveals that John Doe is listed as manager effective October 11, 2023. A manager (which meets the definition of managing employee, per 42 C.F.R. § 424.502) is required to be reported on the 855S enrollment record.]]*

During this stay, claims for services and items you furnish during this period will be rejected. H o w e v e r , this does not affect your Medicare participation agreement or any of its conditions, and you remain enrolled in the Medicare program.

[In order to maintain enrollment in the Medicare program, you must submit a CMS 855 Change of Information Application. Failure to do so by [today's date + 30] may result in a deactivation or revocation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN; however, you will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs to be updated.

*[Name] | **NPI** [NPI] | **PTAN** [PTAN]*

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

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OR, as applicable

Name and address of MAC

For DMEPOS:

Chags Health Information Technology LLC
P.O. Box 45266
Jacksonville, FL 32232]

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

Sincerely,

[Name]

[Title]

[Company]