

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13717	Date: July 8, 2026
	Change Request 14220

SUBJECT: Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08 - Calendar Year (CY) 2026 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 CY 2026 HH PPS final rule.

EFFECTIVE DATE: January 1, 2026

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

IMPLEMENTATION DATE: August 7, 2026

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	10/10.2/10.2.5.1/DMEPOS Supplier Accreditation
R	10/10.4/10.4.1.4.3/Rejections
R	10/10.4/10.4.2.2/Denial Reasons
R	10/10.4/10.4.4/Changes of Information
R	10/10.4/10.4.6/Reactivations
R	10/10.4/10.4.7.2/Revocation Effective Dates
R	10/10.4/10.4.7.3/Revocation Reasons
R	10/10.4/10.4.8/Deactivations
N	10/10.4/10.4.8.2/Rebuttals for Ordering/Certifying Deactivations
R	10/10.4/10.4.9/Stay of Enrollment
N	10/10.6/10.6.1.1.6/DMEPOS Supplier Change in Majority Ownership
R	10/10.6/10.6.2/Establishing Effective Dates
R	10/10.7/10.7.12/Deactivation Model Letters
R	10/10.7/10.7.15/Revalidation Notification Letters
R	10/10.7/10.7.20/Stay of Enrollment Letters
N	10/10.7/10.7.21/DMEPOS Supplier Change in Majority Ownership Letter

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The MAC 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: 13717	Date: July 8, 2026	Change Request: 14220
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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 CY 2026 HH PPS final rule.

II. GENERAL INFORMATION

A. Background: The CY 2026 HH PPS final rule (90 Federal Register 29108) contains provisions concerning Medicare provider enrollment and the accreditation of suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These include, but are not limited to--(1) Expanding the reasons for which a retroactive revocation effective date can be applied; (2) Modifying reassignment effective dates; (3) Shortening the timeframe in which adverse legal action additions/changes must be reported; (4) Establishing a new deactivation basis involving Form CMS-855O enrollments; (5) Applying the "36-month rule" to DMEPOS supplier changes in majority ownership; (6) Requiring the annual reaccreditation of DMEPOS suppliers; and (7) Modifying the stay of enrollment process. This CR will update Chapter 10 of CMS Pub. 100-08 with instructions regarding these regulatory provisions.

B. Policy: CY 2026 HH PPS final rule.

III. 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	HH H		FIS S	MC S	VM S	CW F	
14220.1	The contractor shall observe the change in the DMEPOS reaccreditation timeframe from every three years to annually.									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	
14220.2	Per Section 10.4.7.2 in Chapter 10 of CMS Pub. 100-08, the contractor shall observe and apply the new retroactive effective dates for certain revocation grounds.	X	X	X						NPEAS T, NPWES T
14220.3	In Section 10.4.4 of Chapter 10 in CMS Pub. 100-08, the contractor shall observe the reduction of the timeframe for certain providers and suppliers to report adverse legal action additions/changes from 90 days to 30 days.	X	X	X						
14220.4	In Section 10.4.8(B) of Chapter 10 in CMS Pub. 100-08, the contractor shall observe the new deactivation reason for Form CMS-8550-enrolled individuals who have not ordered, certified, or referred certain		X							

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	
	services and items for 12 consecutive months.									
14220.5	The contractor shall observe and, as applicable, apply the procedures in Section 10.6.1.1.6 of Chapter 10 in CMS Pub. 100-08, regarding DMEPOS supplier changes in majority ownership.									NPEAS T, NPWES T
14220.6	The contractor shall observe and apply the reassignment effective dates in Section 10.6.2 of Chapter 10 in CMS Pub. 100-08.		X							
14220.7	The contractor shall observe and adhere to all stay of enrollment policies regarding rejections of revalidation applications.	X	X	X						NPEAS T, NPWES T

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The MAC 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. 13717; Issued: 07-08-26)

Transmittals for Chapter 10

10.4.8.2 – Rebuttals for Ordering/Certifying Deactivations

10.6.1.1.6 – DMEPOS Supplier Change in Majority Ownership

10.7.21 – DMEPOS Supplier Change in Majority Ownership Letter

10.1.1 – Definitions

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

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. For purposes of this definition only, the term “organization” means the enrolling entity as identified by its legal business name and tax identification number.

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 – *with respect to HHAs and hospices* -- 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 – *except in the situations described in § 424.547* -- 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.

Indirect ownership interest means as follows:

(1)(i) Any ownership interest in an entity that has an ownership interest in the enrolling or enrolled provider or supplier; or

(ii) Any ownership interest in an indirect owner of the enrolling or enrolled provider or supplier.

(2) The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the provider or supplier, A's interest equates to an 8 percent indirect ownership interest in the provider or supplier and must be reported on the enrollment application. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the provider or supplier, B's interest equates to a 4 percent indirect ownership interest in the provider or supplier and need not be reported.

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 means (for purposes of 42 CFR Part 424, subpart P) all the following:

- (1) The individuals and entities that qualify as suppliers under § 400.202
- (2) Physical therapists in private practice
- (3) Occupational therapists in private practice
- (4) Speech-language pathologists

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.

10.2.5.1 – DMEPOS Supplier Accreditation

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. General Requirement

DMEPOS suppliers must be accredited prior to submitting an application to the contractor. The contractor shall deny any DMEPOS supplier's enrollment application if the enrollment package does not contain an approved accreditation upon receipt.

Per § 424.57(c)(24), DMEPOS suppliers must be surveyed and reaccredited at least once every 12 months. The prior 3-year timeframe no longer applies.

The contractor shall revoke an enrolled DMEPOS supplier's billing privileges if the supplier fails to: (1) obtain and submit supporting documentation that it has been accredited; or (2) maintain its required accreditation.

Medicare *denies* claims for DMEPOS suppliers that fail to maintain accreditation information on file with the contractor.

B. Exemptions

Individual medical practitioners, inclusive of group practices of same, do not require accreditation as a condition of enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists, and suppliers who provide drugs and pharmaceuticals (only) do not require accreditation as a condition of enrollment.

Although suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement, suppliers that provide equipment to administer drugs or pharmaceuticals must be accredited.

C. Changes of Ownership

See section 10.6.1.1.6 of this chapter for information regarding the impact of ownership changes on accreditation.

D. Accreditation and Deactivation/Revocation

A non-exempt DMEPOS supplier requesting reactivation after a deactivation (regardless of the deactivation reason) is required to be accredited.

A revoked DMEPOS supplier that has submitted an acceptable corrective action plan can be reinstated without accreditation unless the accreditation was already required prior to revocation.

10.4.1.4.3 - Rejections

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Background

1. Rejection Reasons

a. Section 424.525(a)(1)(i) through (x) – Submission of Complete Information

In accordance with 42 CFR § 424.525(a)(1)(i) through (x), the contractor (including an NPE) may reject the provider's application if the provider fails to furnish complete information on the enrollment application within 30 calendar days from the date the contractor requested the missing information. For purposes of this policy, this includes situations where the provider submitted an application that falls into one of the following categories and, upon the contractor's request to submit a new or corrected complete application, the provider failed to do so within 30 days of the request:

(i) The application is missing data required by CMS or the contractor to process the application (such as, but not limited to, names, Social Security Number, contact information, and practice location information).

(ii) The application is unsigned or undated.

(iii) The application contains a copied or stamped signature.

(iv) The application is signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application.

(v) The application is signed by a person unauthorized to do so under this 42 CFR Part 424, subpart P.

(vi) For paper applications, the required certification statement is missing.

(vii) The paper application is completed in pencil.

(viii) The application is submitted via fax or e-mail when the provider or supplier was not otherwise permitted to do so.

(ix) The provider or supplier failed to submit all of the forms needed to process a Form CMS-855 reassignment package within 30 days of receipt.

(x) The provider or supplier submitted the incorrect Form CMS-855 application. (For example, the provider or supplier submitted a Form CMS-855A application when a Form CMS-855B application was required.)

(Note that certain rejection grounds are inapplicable to PECOS applications (e.g., Form CMS-855 application was completed in pencil, certification statement is missing)).

b. Section 424.525(a)(2) - Documentation

In accordance with 42 CFR § 424.525(a)(2), the contractor (including an NPE) may reject the application if the provider or supplier fails to furnish all required supporting documentation within 30 calendar days of submitting the application.

c. Section 424.525(a)(3) – Application Fee

Consistent with 42 CFR § 424.525(a)(3), the contractor (including an NPE) may reject the application if the institutional provider (as that term is defined in § 424.502) does not submit the application fee in the designated amount or a hardship waiver request (1) with the application at the time of filing and (2) after development for the fee by the contractor. This means that the contractor shall develop for a non-submitted fee rather than return the application. (It need not develop for a waiver, however.) If the institutional provider fails to submit the fee (or a waiver) within 30 days of the request, the contractor can reject the application.

2. Applicability

a. Development

The applications described in subsections (A)(1)(a) through (c) above shall be developed, rather than returned. For instance, if a provider submits an application completed in pencil, the contractor shall request the provider to submit a new application, either in ink or via Internet-based PECOS.

b. Transaction and Form Types

Per § 424.525(e)---and except as otherwise specified in the applicable reason for rejection---§ 424.525(a)(1) through (3) apply to all CMS provider enrollment application submissions, including, but not limited to, the following:

- Form CMS-855 initial applications, change of information requests, changes of ownership, revalidations, and reactivations.
- Form CMS-588 (Electronic Funds Transfer (EFT) Authorization Agreement) submissions.

- Form CMS-20134 (Medicare Enrollment Application; Medicare Diabetes Prevention Program (MDPP) Suppliers) submissions.
- Any electronic or successor versions of the forms identified in paragraphs § 424.525(e)(1) through (3).

B. Timeframe

The 30-day clock identified in § 424.525(a) starts on the date the contractor mails, faxes, or e-mails (e.g., via the PCV) the development letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the development letter was sent. However, the contractor has the discretion to extend the 30-day timeframe if it determines that the provider is actively working with the contractor to resolve any outstanding issues.

C. Incomplete Responses

The provider must furnish all missing and clarifying data and/or documentation requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested information, the contractor is not required to contact the provider again to request the remaining data. It can simply reject the application at the expiration of the aforementioned 30-day period. Consider the following example:

EXAMPLE: A provider submits a Form CMS-855A in which Section 3 is blank. On March 1, the contractor requests that Section 3 be fully completed. On March 14, the provider submits an application with the Final Adverse Action History question completed. However, the report of each adverse action, date, applicable body, and resolution data fields remains blank. The contractor need not make a second request for this data to be furnished. It can reject the application on March 31, or 30 days after its initial request was made.

D. Creation - Paper Applications Only

If the contractor cannot complete the intake or data entry process in PECOS because of missing data and the application is subsequently rejected, the contractor shall disposition the application accordingly in PECOS consistent with existing CMS guidance.

E. Other Impacts of a Rejection

1. Changes of Information and CHOWs

a. Expiration of Timeframe for Reporting Changes - If the contractor rejects a change of information or CHOW submission per this chapter and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its PEOG BFL notifying him or her of the rejection. PEOG will determine whether the provider/supplier's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor rejects a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referenced in subsection (E)(1)(a) above after the expiration of said time period unless the provider/supplier has resubmitted the change request/CHOW.

c. Second Rejection, Return, or Denial – If, per subsection (E)(1)(b) above, the provider resubmits the change of information or CHOW application and the contractor either rejects it again, returns it, or denies it, the contractor shall send the e-mail referenced in subsection

(E)(1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated or revoked and will notify the contractor of its decision.

F. Reactivations

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

G. Revalidations

The contractor shall abide by the following scenarios:

- If the contractor rejects a revalidation application per this chapter 10, the contractor shall – unless an existing CMS instruction or directive states otherwise – *place a stay on the provider/supplier's enrollment under 42 CFR § 424.541(a)(1)* if the applicable *90-day* time period for submitting the revalidation application has expired.
- If it has not expired, the contractor shall *place a stay on the provider/supplier's enrollment* after the applicable time period expires unless the provider/supplier has resubmitted the revalidation application.
- If the provider/supplier indeed resubmits the application and the contractor rejects it again, returns it, or denies it, the contractor shall – absent a CMS instruction to the contrary - deactivate the provider's billing privileges, assuming the applicable time period has expired.

See section 10.4.9 of this chapter for information on the stay of enrollment process.

H. Additional Rejection Policies

1. Resubmission after Rejection

If the provider's application is rejected, the provider must complete and submit a new Form CMS-855 or CMS-20134 (either via paper or Internet-based PECOS) and all necessary documentation.

2. Applicability

Unless stated otherwise in this chapter or another CMS directive, this section 10.4.1.4.3 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, CHOW applications, revalidations, and reactivations).

3. Physicians and Non-Physician Practitioners

Incomplete applications submitted by physicians and non-physician practitioners shall be rejected (unless a denial reason exists) if they fail to provide the requested information within the designated timeframe.

4. Notice

If the contractor rejects an application, it shall notify the provider via letter (sent via fax, mail, the PCV, or e-mail) that the application is being rejected, the reason(s) for the rejection, and how to reapply. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider no later than 5 business days after the contractor concludes that the provider's application should be rejected.

If the rejection also triggers a stay of enrollment per CMS guidance (e.g., under section 10.4.9), the contractor shall use the rejection/stay letter in section 10.7.20 of this chapter.

5. Copy of Application

Paper Applications - If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents or (2) maintain the scanned submission of the application and documents in PECOS and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

PECOS – Since the application was submitted electronically via PECOS and all supporting documents were uploaded consistent with section 10.3 of this chapter, the contractor need not return any documents to the provider.

10.4.2.2 - Denial Reasons

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Denial Reason 1– Not in Compliance with Medicare Requirements (42 CFR §424.530(a)(1))

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

- i. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- ii. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- iii. The provider or supplier is not appropriately licensed.
- iv. The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- v. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. (See section 10.2.8 of this chapter for examples of suppliers that are not eligible to participate.)
- vi. The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.
- vii. The applicant does not qualify as a provider of services or a supplier of medical and health services. (For instance, the applicant is not recognized by any federal statute as a Medicare provider or supplier (see section 10.2.8 of this chapter.)) An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions in § 1842(b)(6) of the Act (42 U.S.C. 1395u(b)).
- viii. The provider or supplier does not otherwise meet general enrollment requirements.

(With respect to (v) above – and, as applicable, (iii) and (iv) - the contractor’s denial letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider or supplier type. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

NOTE: The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) with which the provider/supplier is non-compliant.

(NOTE: For (a)(1) denials involving an individual practitioner who is not appropriately licensed due to a disciplinary action, PEOG -- rather than the contractor -- will make all denial determinations for this noncompliance requirement).

B. Denial Reason 2– Excluded/Debarred from Federal Program (42 CFR § 424.530(a)(2))

(i) “The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel (such as a billing specialist, accountant, or human resources specialist) furnishing services payable by a federal health care program, of the provider or supplier is—

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

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

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.

(Unless stated otherwise in section 10.6.6 of this chapter or in another CMS directive, the contractor need not review the OIG exclusion list for any “health care or administrative or management services personnel” who are not otherwise required to be reported on the enrollment application.)

C. Denial Reason 3 – Felony Conviction (42 CFR § 424.530(a)(3))

“The provider, supplier, or any owner, managing employee, managing organization, officer, director, of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries.

(i) Offenses include, but are not limited in scope and severity to:

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

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

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

(D) Any felonies outlined in section 1128 of the Social Security Act.

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

(iii) The individuals and organizations identified in paragraph (a)(3) of this section include, but are not limited to, W-2 employees and contracted individuals and organizations of the provider or supplier.”

While a reenrollment bar is established for revoked providers/suppliers, this does not preclude the contractor from denying reenrollment to a provider/supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all of the criteria necessary to enroll in Medicare.

Note that if an MDPP coach meets the above felony requirements, this would not itself warrant a denial of the MDPP supplier under § 424.535(a)(3). This is because the coach, not the MDPP supplier, has the felony conviction. The MDPP supplier could, however, be denied enrollment under § 424.530(a)(1) (non-compliance with enrollment requirements) for having an ineligible coach.

As explained in section 10.6.6 of this chapter, the contractor shall submit all felonies found on Form CMS-855 and CMS-20134 applications to PEOG for review via ProviderEnrollmentRevocations@cms.hhs.gov. (See section 10.6.6 for more information.)

D. Denial Reason 4– False or Misleading Information on Application (42 CFR § 424.530(a)(4))

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

E. Denial Reason 5– On-Site Review/Other Reliable Evidence that Requirements Not Met (42 CFR §424.530(a)(5))

“Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

- (i) Is not operational to furnish Medicare-covered items or services; or
- (ii) Otherwise fails to satisfy any Medicare enrollment requirement.”

F. Denial Reason 6– Medicare Debt (42 CFR § 424.530(a)(6))

1. Background

Consistent with 42 CFR § 424.530(a)(6), an enrollment application may be denied if:

(i) The provider, supplier, or owner thereof (as defined in § 424.502) has an existing Medicare debt:

(ii) The enrolling provider, supplier, or owner (as defined in § 424.502) thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the

latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all the following criteria are met:

(A) The owner left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination, or revocation.

(B) The Medicare debt has not been fully repaid.

(C) CMS determines that the uncollected debt poses an undue risk of fraud, waste, or abuse. In making this determination [under § 424.530(a)(6)(ii)], CMS considers the following factors:

(1) The amount of the Medicare debt.

(2) The length and timeframe that the enrolling provider, supplier, or owner thereof was an owner of the prior entity.

(3) The percentage of the enrolling provider, supplier, or owner's ownership of the prior entity.

(4) Whether the Medicare debt is currently being appealed.

(5) Whether the enrolling provider, supplier, or owner thereof was an owner of the prior entity at the time the Medicare debt was incurred.”

In addition, a denial of Medicare enrollment under paragraph (a)(6)(ii) can be avoided if the enrolling provider, supplier, or owner thereof does either of the following: (1) satisfies the criteria set forth in § 401.607 and agrees to a CMS-approved extended repayment schedule for the entire outstanding Medicare debt; or (2) repays the debt in full.

2. Contractor's Determination of Overpayment

When processing a Form CMS-855A, CMS-855B, CMS-855I, CMS-855S, or CMS-20134 initial or change of ownership application (if applicable), the contractor shall determine – using a system generated monthly listing – whether the provider, supplier, or any owner listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment, as described in section 10.4.2.2(F)(1) above and § 424.530(a)(6). If such an overpayment exists, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior PEOG approval is required before proceeding with the denial. The contractor shall under no circumstances deny an application under § 424.530(a)(6) without receiving PEOG approval to do so.

3. Examples

Example #1: Dr. X, a sole proprietor, has a \$70,000 overpayment. Three months later, Dr. X joins Group Y and becomes a 50 percent owner thereof. Group Y submits an initial enrollment application two months thereafter. Group Y's enrollment could be denied because Dr. X is an owner.

Example #2: Dr. Smith's practice (“Smith Medicine”) is set up as a sole proprietorship. Dr. Smith incurs a \$50,000 overpayment. Dr. Smith terminates Medicare enrollment. Six months later, Dr. Smith tries to enroll as a sole proprietorship; the practice is named “JS Medicine.” A denial is warranted because § 424.530(a)(6) applies to physicians and the \$50,000 overpayment was attached to Dr. Smith as the sole proprietor.

Example #3 - Same scenario as example #2 but assume that Dr. Smith's new practice is an LLC of which Dr. Smith is only a 30 percent owner. A denial is still warranted because Dr. Smith is an owner of the enrolling supplier and the \$50,000 overpayment was attached to Dr. Smith.

Example #4 - Smith is a nurse practitioner in a solo practice. The practice ("Smith Medicine") is set up as a closely held corporation, of which Smith is the 100 percent owner. Smith Medicine is assessed a \$20,000 overpayment. Smith terminates the Medicare enrollment. Nine months later, Smith submits a Form CMS-855I application to enroll Smith as a new individual supplier. The business will be established as a sole proprietorship. A denial is not warranted because the \$20,000 overpayment was attached to Smith Medicine, not to Smith.

In each of these examples, however, denial could be avoided if (1) the party with the overpayment is on a Medicare-approved plan of repayment or (2) the overpayments in question are currently being offset or being appealed.

4. Additional Considerations Involving § 424.530(a)(6)

The contractor shall also observe the following with respect to § 424.530(a)(6):

- a. In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.
- b. The instructions in this section 10.4.2.2(F) apply only to (i) initial enrollments and (ii) new owners in a change of ownership.
- c. The term "owner" under § 424.502 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 1124A(A) of the Act.
- d. If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 10.4.2.2(F), the contractor shall not deny the application based on § 424.530(a)(6).

G. Denial Reason 7– Medicare or Medicaid Payment Suspension (42 CFR § 424.530(a)(7))

- (i) The provider or supplier, or any owning or managing employee or organization of the provider or supplier, is currently under a Medicare or Medicaid payment suspension as defined in §§ 405.370 through 405.372 or in § 455.23 of this chapter.
- (ii) CMS may apply the provision in this paragraph (a)(7) to the provider or supplier under any of the provider's, supplier's, or owning or managing employee's or organization's current or former names, numerical identifiers, or business identities or to any of its existing enrollments.
- (iii) In determining whether a denial is appropriate, CMS considers the following factors:
 - (A) The specific behavior in question.
 - (B) Whether the provider or supplier is the subject of other similar investigations.
 - (C) Any other information that CMS deems relevant to its determination.

H. Denial Reason 8– Home Health Agency (HHA) Capitalization (42 CFR § 424.530(a)(8))

An HHA submitting an initial application for enrollment:

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

I. Denial Reason 9– Hardship Exception Denial and Fee Not Paid (42 CFR § 424.530(a)(9))

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

(This denial reason should only be used when the institutional provider fails to submit the application fee after its hardship request was denied. The contractor shall use § 424.530(a)(1) as a basis for denial when the institutional provider: (a) does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes; or (b) submits the fee, but it cannot be deposited into a government-owned account.)

J. Denial Reason 10– Temporary Moratorium (42 CFR § 424.530(a)(10))

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

K. Denial Reason 11 – Prescribing Authority (42 CFR § 424.530(a)(11))

“1. A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause; or

2. The applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe *one or more* drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits the enrollment application to the Medicare contractor.”

(Except as otherwise stated in this chapter or in another CMS directive, the contractor need not verify whether an individual’s DEA certificate was surrendered in response to a show cause order.)

NOTE: With respect to (a)(11), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

L. Denial Reason 12 (42 CFR § 424.530(a)(12) - Revoked Under Different Name, Numerical Identifier, or Business Identity)

“The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired. In making its determination, CMS considers the following factors:

- (i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);
- (ii) Geographic location;
- (iii) Provider or supplier type;
- (iv) Business structure; or
- (v) Any evidence indicating that the two parties [the revoked provider/supplier and the newly-enrolling provider/supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar.”

NOTE: With respect to (a)(12), PEOG – rather than the contractor – will make all determinations regarding whether a provider or supplier was revoked under a different name, numerical identifier or business identity.

M. Denial Reason 13 (42 CFR § 424.530(a)(13) - Affiliation that Poses an Undue Risk)

“The provider or supplier has or has had an affiliation under 42 CFR § 424.519 (specifically, the factors listed in 42 CFR § 424.519(f)) that poses an undue risk of fraud, waste, and abuse to the Medicare program.”

An affiliation is defined as any of the following:

- (i) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
- (ii) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.
- (iii) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of § 424.519 only, sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization.
- (iv) An interest in which an individual is acting as an officer or director of a corporation.
- (v) Any reassignment relationship under § 424.80.

NOTE: With respect to (a)(13), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has an affiliation per 42 CFR § 424.519 that poses an undue risk of fraud, waste and abuse.

N. Denial Reason 14 (42 CFR § 424.530(a)(14) – Other Program Termination or Suspension)

“(1) The provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or (2) the provider or supplier’s license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling.”

In determining whether a denial under § 424.530(a)(14) is appropriate, CMS considers the following factors:

- a. The reason(s) for the termination, suspension, or revocation;
- b. Whether, as applicable, the provider or supplier is currently terminated or suspended (or otherwise barred) from more than one program (for example, more than one state's Medicaid

program), has been subject to any other sanctions during its participation in other programs or by any other state licensing boards, or has had any other final adverse actions (as that term is defined in § 424.502) imposed against it; and

c. Any other information that CMS deems relevant to its determination.”

NOTE: With respect to (a)(14), PEOG -- rather than the contractor – will make all determinations regarding whether a provider or supplier has a termination or suspension from another program or has a license that is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling.

O. Denial Reason 15 (42 CFR § 424.530(a)(15) – Patient Harm)

“The physician or other eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a denial is appropriate, CMS considers the following factors:

(A) The nature of the patient harm

(B) The nature of the physician's or other eligible professional's conduct

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by a state oversight board, IRO, federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to, procedures or practices; (ii) required compliance appearances before state oversight board members; (iii) license restriction(s) regarding the ability to treat certain types of patients; (iv) administrative/monetary penalties; and (v) formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon.”

Section 424.530(a)(15) does not apply to actions or orders pertaining exclusively to either of the following: (i) required participation in rehabilitation or mental/behavioral health programs; or (ii) required abstinence from drugs or alcohol and random drug testing.

NOTE: With respect to (a)(15), PEOG -- rather than the contractor – will make all determinations regarding whether this provision applies.

P. Denial Reason 17 – False Claims Act Judgment (42 CFR § 424.530(a)(17))

“(i) The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the False Claims Act (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(ii) In determining whether a denial under this paragraph is appropriate, CMS considers the following factors:

(A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted)

(B) The types of provider or supplier actions involved

(C) The monetary amount of the judgment

(D) When the judgment occurred

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502)

(F) Any other information that CMS deems relevant to its determination.”

NOTE: With respect to (a)(17), PEOG -- rather than the contractor -- will make all determinations regarding whether this provision applies.

Q. Denial Reason 18 – Standard or Condition Violation (42 CFR § 424.530(a)(18))

(i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g).

(ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).

(iii) The opioid treatment program is non-compliant with any provision in § 424.67(b) or (e).

(iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).

(v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (c).

(All denials based wholly, or in part, on § 424.530(a)(18) shall be sent to PEOG to obtain approval of both the denial action itself and the denial letter. The contractor’s denial letter shall cite the exact statutory and/or regulatory citation(s) containing the specific standard/condition with which the provider/supplier is non-compliant. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

(See section 10.4.2.3 for more information regarding § 424.530(a)(18).)

10.4.4 – Changes of Information

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. General Information

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

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

(ii) In the event an instruction in sections 10.6.1 et seq. or 10.6.22 et seq. of this chapter contradicts that in this section 10.4.4, the section 10.6.1 et seq. or 10.6.22 et seq. guidance takes precedence (e.g., transitioned certified provider/supplier change of information instructions in section 10.6.1.2 of this chapter).

(iii) Except as otherwise specified in this chapter or another CMS directive, if an enrolled provider/supplier is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855 or CMS-20134. (Letterhead is impermissible.) The provider/supplier shall: (a) furnish the

changed data in the applicable section(s) of the form; and (b) sign and date the certification statement.

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

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

(For purposes of the regulatory provisions referenced in this section 10.4.4(B) (e.g., § 424.57(c)(2)):

- A practice location “change” includes location additions, deletions, and relocations.
- All practice location changes – regardless of the provider or supplier type involved – must be reported within 30 days of the change.)
- *All adverse legal action additions/changes – regardless of the provider or supplier type involved -- must be reported within 30 days of the change.*

1. Physicians/Non-Physicians/Groups

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

2. DMEPOS Suppliers

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

3. IDTFs

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

4. MDPP Suppliers

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

5. All Other Provider/Supplier Types

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

(i) Changes of ownership or control (including changes in authorized official(s) or delegated official(s)); change of practice location; *and adverse legal action additions/changes* – 30 days

(ii) All other changes – 90 days

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

C. Signatories and Notifications

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

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

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

(ii) Document PECOS (per sections 10.3 and 10.6.19 of this chapter) with the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP code change, the contractor need not send confirmation to the provider that it has processed the change.

3. Confirmation of Change in Practice Location Address

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

D. Change in Special Payments Address

Note that the instructions in this subsection (D) are in addition to, and not in lieu of, those in section 10.6.23 and vice versa.

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

2. Revalidation - When processing a revalidation application, the contractor shall (unless another CMS directive instructs otherwise) follow the instructions in sections 10.4.4(D) and 10.4.4(C)(3) above, respectively, if the practice location address or special payment address on the application is different from that currently associated with the provider in PECOS or MCS.

E. Provider or Supplier Changing Specialty Type

With the exception of individual physicians and certain situations described in section 10.3 of this chapter, providers and suppliers who wish to change their enrolled provider/supplier type must terminate their current enrollment and submit an initial enrollment application (Screening and an application fee (if applicable) applies for the new enrollment.)

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

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

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

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

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

- (i) Processing the complete application consistent with the timeframes for initial applications outlined in this chapter.
- (ii) Validate all data elements on the Form CMS-855 or CMS-20134 consistent with the instructions in this chapter pertaining to initial applications. The contractor shall not approve the change request until it has verified all data on the complete Form CMS-855 or CMS-20134 consistent with the instructions in this chapter.
- (iii) Creating a record in PECOS prior to approving the change request. (The receipt date should be the date on which the complete application was received, not the date on which the initial change request was received.) The transaction should be treated as an initial enrollment in PECOS; internally, the contractor shall treat it as a change of information. As the complete application will presumably incorporate the changed data reported on the original Form CMS-855 or CMS-20134 change request, the contractor shall not take two separate counts (one initial and one change request) for the transaction. (NOTE: Any PECOS 2.0 policies or procedures that are contrary to those in this subparagraph (iii) take precedence over the latter.)

G. Incomplete or Unverifiable Changes of Information

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

There can be instances where a provider has an enrollment record in PECOS and submits a change request but: (1) fails to timely respond to the contractor’s request for additional or

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

H. Change of EFT Information

(Note that the instructions in this subsection (H) are in addition to, and not in lieu, those in section 10.6.23 and vice versa.)

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

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

1. Timeframe for State Review

In situations where state and/or SOG Location review of the change of information is required (see sections 10.6.1.2 and 10.6.22.1), the contractor may (via any means) advise the provider that it may take several months for the request to be approved.

2. Post-Recommendation Changes

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

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

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

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

The contractor shall contact the appropriate SOG Location while processing the Form CMS-855A to verify that the CAH's new provider-based location is more than 35 miles (15 miles in the case of mountainous terrain or an area with only secondary roads) from the main

campus of another hospital or CAH. The contractor may not make a recommendation for approval without receiving a response from the SOG Location.

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

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

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

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

10.4.6 – Reactivations

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Reactivations of Enrollment/Billing Privileges

1. Form CMS-855 or CMS-20134 Reactivations – Screening Levels

a. Limited

The contractor shall process reactivation applications from providers in the "limited" level of categorical screening in accordance with existing instructions.

b. Moderate

The contractor shall process reactivation applications from providers in the "moderate" level of categorical screening (including existing HHAs and DMEPOS suppliers) in accordance with the screening procedures for this category. A site visit is thus needed prior to the contractor's final decision regarding the application.

c. High

The contractor shall process reactivation applications from providers in the "high" level of categorical screening in accordance with the screening procedures for this category. A site visit is thus needed prior to the contractor's final decision regarding the application.

2. Form CMS-855B and CMS-855I Non-Certified Supplier Reactivations

If the contractor approves a Part B non-certified supplier's reactivation application, the reactivation effective date shall be the date the contractor received the application that was processed to approval. In addition, upon reactivating a Part B non-certified supplier, the contractor shall issue a new PTAN; for PECOS applications (and as indicated in section 10.3 of this chapter), PECOS will automatically issue a new PTAN.

3. Form CMS-855A or CMS-855B Certified Provider or Supplier Reactivations

With the exception of HHAs, reactivation of a certified provider/supplier does not require a new state survey, provider agreement, or participation agreement. Per 42 CFR § 424.540(b)(3)(i), an HHA must undergo a new state survey or obtain accreditation by an approved accreditation organization before it can be reactivated.

4. Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim

To reactivate its billing privileges, the provider or supplier must submit a complete Medicare enrollment application if the provider or supplier was deactivated: (i) for failing to timely notify the contractor of a change of information; or (ii) under § 424.540(a)(4) and (a)(5).

5. Reactivation Effective Date

Per 42 CFR § 424.540(d)(2), the effective date of a reactivation of billing privileges under this section is the date on which the contractor received the provider's or supplier's reactivation submission that the contractor processed to approval. Under 42 CFR § 424.540(e), however, the provider or supplier may not receive payment for services or items furnished while deactivated. This means that the contractor shall not add a retroactive back-billing period (e.g., 30 days) to the reactivation effective date. To illustrate, suppose the contractor establishes a reactivation effective date under § 424.540(d)(2) of October 30, the date the contractor received the ultimately approved reactivation submission. The contractor under § 424.540(e) cannot establish an effective date earlier than October 30 to allow for additional retroactive billing.

6. Miscellaneous Policies

a. Previous Withdrawn Status

A provider that voluntarily withdraws (or, in the case of a certified provider/supplier, voluntarily or involuntarily withdraws from Medicare enrollment) is ineligible for reactivation. Such a provider must complete an initial enrollment application and, if applicable, pay an application fee.

b. Deactivation for Non-Billing

For providers deactivated for non-billing, the provider must submit a complete Form CMS-855 or CMS-20134 enrollment application via paper or PECOS Web.

c. Contractor Timeliness Standards

For Form CMS-855 or CMS-20134 reactivation applications, the timeliness requirements in section 10.5 et seq. of this chapter pertaining to initial enrollment applications apply. Except as otherwise stated in this chapter or another CMS directive, the contractor shall validate all of the information on the application as it would with an initial application.

B. Ordering/Certifying Reactivations Under § 424.547

See section 10.4.8(B) of this chapter for information on reactivations of physicians/practitioners whose ability to order/certify/refer the Medicare services and items identified in § 424.507(a) and (b) were deactivated per § 424.547.

10.4.7.2 – Revocation Effective Dates

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Effective Dates

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

1. Revocations with Retroactive Effective Dates (§ 424.535(g)(2))

These revocation grounds require the *following* retroactive effective dates per § 424.535(g)(2):

- (i) Federal exclusion or debarment – Date of exclusion/debarment*
- (ii) Felony conviction – Date of felony conviction*
- (iii) License suspension or revocation – Date of license suspension or revocation*
- (iv) Determination that the provider or supplier is no longer operational – Date provider/supplier no longer operational*
- (v) State license surrender in lieu of further disciplinary action – Date of license surrender*
- (vi) Termination from a federal health care program other than Medicare (for example, Medicaid) – Date of termination*
- (vii) Termination of a provider agreement under 42 CFR Part 489 – Later of date of provider agreement termination or date CMS establishes under § 489.55*
- (viii) Lapse in IDTF's comprehensive liability insurance policy under § 410.33(g)(6) – Date insurance lapsed*
- (ix) Submission of false or misleading information on the enrollment application - Date the application's certification statement was signed*
- (x) Failure to timely report a change of ownership or adverse legal action, or a change, addition, or deletion of a practice location – Day after the date by which the provider or supplier was required to report the change, addition, or deletion*
- (xi) Surrender of Drug Enforcement Administration certificate of registration in response to a show cause order - Date the certificate was surrendered*
- (xii) State suspension or revocation of the physician's/practitioner's ability to prescribe one or more drugs - Date of the suspension or revocation*
- (xiii) Revocation of any of the provider's or supplier's other enrollments under § 424.535(i) - The effective date of the revocation that triggered the revocation(s) of the other enrollment(s)*
- (xiv) DMEPOS supplier's non-compliance with a condition or standard in § 424.57(b) or (c) – Date on which the non-compliance began*

(xv) Violation of provider or supplier standard as described in 42 CFR §§ 424.535(a)(23) -

- If the standard or condition violation involves the suspension, revocation, or termination (or surrender in lieu of further disciplinary action) of the provider's or supplier's federal or state license, certification, accreditation, or MDPP recognition, the effective date is the date of the license, certification, accreditation, or MDPP recognition suspension, revocation, termination, or surrender.*
- If the standard or condition violation involves a non-operational practice location, the effective date is the date the non-operational status began.*
- If the standard violation involves a felony conviction of an individual or entity described in § 424.67(b)(6)(i), the effective date is the date of the felony conviction.*

(For all standard violations not addressed in § 424.535(g)(2) above, the effective date in § 424.535(g)(1) (see below) applies if the effective date in § 424.535(g)(3) does not.)

In addition, and as stated in § 424.535(a)(8)(iii), the following effective dates apply to revocations under § 424.535(a)(8):

- § 424.535(a)(8)(i) – The earliest date of service on the claim or claims that is or are triggering the revocation*
- § 424.535(a)(8)(ii) – The last date of service on the claims in question*

2. Revocations with Prospective Effective Dates (§ 424.535(g)(1))

The contractor shall use a prospective effective date (i.e., the date that is 30 days after CMS or the CMS contractor mails notice of its determination to the provider) for revocations not based upon one of the reasons listed in §§ 424.535(g)(2) and section 10.4.7.2(A)(1) above (e.g., § 424.535(a)(8) -- abuse of billing).

3. Pre-Enrollment Actions (§ 424.535(g)(3))

If the action that triggered the revocation occurred before the provider's or supplier's enrollment, the revocation effective date is the enrollment effective date that CMS assigned to the provider or supplier. To illustrate, for a revocation involving an adverse legal action that occurred on February 1 (of which CMS was not aware) and the provider was enrolled effective April 1, the revocation effective date would be April 1 rather than February 1. Strictly for purposes of applying § 424.535(g)(3) -- and notwithstanding any guidance to the contrary in section 10.6.2 of this chapter – the effective date of enrollment is the date that was established under §§ 424.520 or 424.521, whichever is earlier.

B. Revocations Based Upon More than One Reason

When a revocation involves more than one reason, the contractor shall determine whether any of the grounds require a retroactive effective date (as described above in section 10.4.7.2(A) above; if a retroactive date is indeed implicated, the contractor shall apply the appropriate retroactive date.

10.4.7.3 – Revocation Reasons

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

Sections 10.4.7.3(A) through (V) list the revocation reasons in 42 CFR § 424.535. Section 10.4.7.3(W) discusses extensions of revocations per 42 CFR § 424.535(i).

A. Revocation Reason 1 – Noncompliance (42 CFR § 424.535(a)(1))

“The provider or supplier is determined not to be in compliance with the enrollment requirements in this Title 42 or in the enrollment application applicable to its provider or supplier type and has not submitted a plan of corrective action as outlined in 42 CFR Part 488. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.”

(Title 42 includes the principal provider enrollment regulations in 42 CFR Part 424, subpart P; the IDTF enrollment standards in 42 CFR § 410.33; the OTP enrollment standards in 42 CFR § 424.67; etc.)

Noncompliance includes but is not limited to: (1) the provider/supplier no longer has a physical business address or mobile unit where services can be rendered; (2) the provider/supplier does not have a place where patient records are stored to determine the amounts due such provider or other person; and/or (3) the provider/supplier no longer meets or maintains general enrollment requirements. Noncompliance also includes situations when the provider/supplier has failed to pay any user fees as assessed under 42 CFR Part 488.

Other situations (some of which were mentioned in the previous paragraph) in which § 424.535(a)(1) may be used as a revocation reason include, but are not limited to, the following:

- The provider or supplier does not have a physical business address or mobile unit where services can be rendered.
- The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.
- The provider or supplier is not appropriately licensed. (NOTE: For (a)(1) revocations involving an individual practitioner who is not appropriately licensed due to a disciplinary action, PEOG -- rather than the contractor -- will make all determinations to revoke for this noncompliance requirement).
- The provider or supplier is not authorized by the federal/state/local government to perform the services that it intends to render.
- The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.
- The provider or supplier does not have a valid social security number (SSN) or employer identification number (EIN) for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or authorized or delegated official.
- The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider/supplier’s notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. (This revocation reason will not apply if CMS has instructed the contractor to use deactivation reason § 424.540(a)(3) in lieu thereof.)
- The provider or supplier does not otherwise meet general enrollment requirements.

(Concerning the last bullet above – and, as applicable, bullets 3, 4 and 5 – the contractor’s revocation letter shall cite the appropriate statutory and/or regulatory citation(s) containing the specific licensure/certification/authorization requirement(s) for that provider/supplier type.)

Special Instructions Regarding Certified Providers/Suppliers – The SOG Location may involuntarily terminate a certified provider/supplier if the latter no longer meets CMS requirements, conditions of participation, or conditions of coverage. When this occurs, CMS terminates the provider/supplier’s provider agreement and notifies the contractor thereof. Upon receipt of the CMS notice (and except as otherwise stated in this chapter), the contractor shall follow the revocation procedures in this chapter (including, as applicable, those in section 10.6.6)), using § 424.535(a)(1) as the revocation basis; the contractor shall not process the involuntary termination as a deactivation based upon a voluntary withdrawal from Medicare.

Note that the contractor need not (but certainly may) contact the SOG Location to obtain further details of the termination.

B. Revocation Reason 2 – Provider or Supplier Conduct (42 CFR § 424.535(a)(2))

“(i) The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management personnel furnishing services payable by a federal health care program, of the provider or supplier is:

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

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

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.”

If the contractor finds an excluded party (and unless section 10.6.6 states otherwise, in which case the latter section takes precedence), the contractor shall notify its PEOG BFL immediately. PEOG will notify the Contracting Officer’s Representative (COR) for the appropriate Unified Program Integrity Contractor (UPIC). The COR will, in turn, contact the OIG for further investigation.

C. Revocation Reason 3 – Felony Conviction (42 CFR § 424.535(a)(3))

“The provider, supplier, or any owner, managing employee, managing organization, officer, or director of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries. [Under § 424.535(a)(3)(ii),] [o]ffenses include, but are not limited in scope and severity to:

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

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

[Under § 424.535(a)(3)(iii),] revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.”]

[Under § 424.535(a)(3)(iv),] the individuals and organizations identified in paragraph (a)(3) of this section include, but are not limited to, W-2 employees and contracted individuals and organizations of the provider or supplier.]

The expiration of a reenrollment bar issued pursuant to 42 CFR § 424.535(c) does not preclude CMS or its contractors from denying reenrollment to a provider that (i) was convicted of a felony within the preceding 10-year period or (ii) otherwise does not meet all criteria necessary to enroll in Medicare.

D. Revocation Reason 4 – False or Misleading Information on Application (42 CFR § 424.535(a)(4))

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

E. Revocation Reason 5 - On-Site Review/Other Reliable Evidence that Requirements Not Met (42 CFR § 424.535(a)(5))

“Upon on-site review or other reliable evidence, CMS determines that the provider or supplier:

- (i) Is not operational to furnish Medicare-covered items or services; or
- (ii) Otherwise fails to satisfy any Medicare enrollment requirement.”

F. Revocation Reason 6 - Hardship Exception Denial and Fee Not Paid (42 CFR §424.535(a)(6))

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

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

(iii) Either of the following occurs:

- CMS is not able to deposit the full application amount into a government-owned account; or
- The funds are not able to be credited to the United States Treasury;

(iv) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

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

G. Revocation Reason 7 – Misuse of Billing Number (42 CFR § 424.535(a)(7))

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

H. Revocation Reason 8 – Abuse of Billing Privileges (42 CFR § 424.535(a)(8))

“Abuse of billing privileges includes either of the following:

(i) The provider or supplier *submits* a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(D) The beneficiary attests that the item(s) or service(s) identified on the provider’s or supplier’s claim or claims was not or were not rendered or furnished.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors:

(A) The percentage of submitted claims that were denied during the period under consideration.

(B) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502) and the nature of any such actions.

(C) The type of billing non-compliance and the specific facts surrounding said non-compliance (to the extent this can be determined).

(D) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination.”

(NOTE: Concerning (a)(8), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider has a pattern or practice of submitting non-compliant claims; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)

I. Revocation Reason 9 – Failure to Report (42 CFR § 424.535(a)(9))

“The provider or supplier failed to comply with the reporting requirements specified in 42 CFR § 424.516(d) or (e), § 410.33(g)(2), or § 424.57(c)(2) [which pertain to the reporting of changes in adverse actions and practice locations].”

With respect to § 424.535(a)(9) (and except as otherwise stated in section 10.6.6):

- If the provider reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not pursue a revocation on this basis. However, if the contractor independently determines – through an on-site inspection under 42 CFR § 424.535(a)(5)(ii) or via another verification process - that the provider’s address has changed but the provider has not notified the contractor thereof within the aforementioned 30-day timeframe, the contractor may pursue a revocation (e.g., seeking PEOG’s approval to revoke).
- If an IDTF reports a change in ownership, change of location, change in general supervision or change in adverse legal action more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG’s approval to revoke).
- If a DMEPOS supplier reports a change of information more than 30 days after the effective date of the change, the contractor may pursue a revocation on this basis (e.g., seeking PEOG’s approval to revoke).

J. Revocation Reason 10 – Failure to Document or Provide CMS Access to Documentation (42 CFR § 424.535(a)(10))

“The provider or supplier did not comply with the documentation requirements specified in 42 CFR § 424.516(f). A provider that furnishes any covered ordered, certified, referred, or prescribed Part A or B services, items or drugs is required to maintain documentation for 7 years.”

K. Revocation Reason 11 - Home Health Agency (HHA) Capitalization (42 CFR § 424.535(a)(11))

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

L. Revocation Reason 12 – Other Program Termination (42 CFR § 424.535(a)(12))

“The provider or supplier is terminated, revoked, or otherwise barred from participation in a particular State Medicaid Agency or any other federal health care program.”

In making its determination, CMS considers the following factors listed in 42 CFR § 424.535(a)(12):

“(A) The reason(s) for the termination or revocation;

(B) Whether the provider or supplier is currently terminated, revoked, or otherwise barred from more than one program (for example, more than one state's Medicaid program) or has been subject to any other sanctions during its participation in other programs; and;

(C) Any other information that CMS deems relevant to its determination.”

Under § 424.535(a)(12)(ii), “Medicare may not revoke [a provider/supplier’s Medicare billing privileges] unless and until the provider or supplier has exhausted all applicable appeal rights or the timeframe for filing an appeal has expired without the provider or supplier filing an appeal.”

M. Revocation Reason 13 - Prescribing Authority (42 CFR § 424.535(a)(13))

“(i) The physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or is surrendered in response to an order to show cause; or

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician’s or other eligible professional's ability to prescribe *one or more* drugs.”

N. Revocation Reason 14 – Improper Prescribing Practices (42 CFR § 424.535(a)(14))

“CMS determines that the physician or other eligible professional has a pattern or practice of prescribing *Medicare-covered* drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both. In making this determination, CMS considers the following factors:

(A) Whether there are diagnoses to support the indications for which the drugs were prescribed;

(B) Whether there are instances when the necessary evaluation of the patient for whom the drug was prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit);

(C) Whether the physician or eligible professional has prescribed controlled substances in excessive dosages that are linked to patient overdoses;

(D) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the State or States in which the individual practices, and the reason(s) for the action(s);

(E) Whether the physician or eligible professional has any history of final adverse actions (as that term is defined in § 424.502);

(F) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined);

(G) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician or eligible professional's ability to prescribe medications, and the reason(s) for any such restriction, suspension, revocation, or termination; and

(H) Any other relevant information provided to CMS.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements. In making this determination, CMS considers the following factors:

(A) Whether the physician or eligible professional has a pattern or practice of prescribing without valid prescribing authority.

(B) Whether the physician or eligible professional has a pattern or practice of prescribing for controlled substances outside the scope of the prescriber's DEA registration.

(C) Whether the physician or eligible professional has a pattern or practice of prescribing drugs for indications that were not medically accepted - that is, for indications neither approved by the FDA nor medically accepted under section 1860D-2(e)(4) of the Act - and whether there is evidence that the physician or eligible professional acted in reckless disregard for the health and safety of the patient.”

(NOTE: Concerning (a)(14), PEOG -- rather than the contractor -- will (1) make all determinations regarding whether a provider/supplier has a pattern or practice of prescribing Part B or D drugs; (2) consider the relevant factors; and (3) accumulate all information needed to make such determinations.)

O. Revocation Reason 15 – False Claims Act Judgment (42 CFR § 424.535(a)(15))

“(i) The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the False Claims Act (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(ii) In determining whether a revocation under this paragraph is appropriate, CMS considers the following factors:

(A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted)

(B) The types of provider or supplier actions involved

(C) The monetary amount of the judgment

(D) When the judgment occurred

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502)

(F) Any other information that CMS deems relevant to its determination.”

NOTE: With respect to (a)(15), PEOG -- rather than the contractor -- will make all determinations regarding whether this provision applies.

P. Revocation Reason 17 – Debt Referred to the United States Department of Treasury (42 CFR § 424.535(a)(17))

“The provider or supplier has failed to repay a debt that CMS appropriately refers to the United States Department of Treasury.” In determining whether a revocation is appropriate, CMS considers the following factors:

“(i)(A) The reason(s) for the failure to fully repay the debt (to the extent this can be determined);

(B) Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined);

(C) Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined);

(D) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions;

(E) The amount of the debt; and

(F) Any other evidence that CMS deems relevant to its determination.”

(NOTE: With respect to (a)(17):

- Section 424.535(a)(17)(ii) excludes from paragraph (a)(17)(i)'s purview those cases where: (1) the provider's or supplier's Medicare debt has been discharged by a bankruptcy court; or (2) the administrative appeals process concerning the debt has not been exhausted or the timeline for filing such an appeal, at the appropriate appeal level, has not expired.
- PEOG – rather than the contractor – will make all (a)(17) determinations.

Q. Revocation Reason 18 – Revoked Under a Different Name, Numerical Identifier or Business Identity (42 CFR § 424.535(a)(18))

“The provider or supplier is currently revoked [from Medicare] under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired.” In making its determination, CMS considers the following factors:

“(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS-855 [or CMS-20134] application);

(ii) Geographic location;

(iii) Provider or supplier type;

(iv) Business structure; or

(v) Any evidence indicating that the two parties [the revoked provider or supplier and newly enrolling provider or supplier] are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar.”

(NOTE: Concerning (a)(18), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier was revoked under a different name, numerical identifier, or business identity.)

R. Revocation Reason 19 – Affiliation that Poses an Undue Risk (42 CFR § 424.535(a)(19))

1. Specific Reason

“The provider or supplier has or has had an affiliation under 42 CFR § 424.519 that poses an undue risk of fraud, waste and abuse to the Medicare program.” In making this determination, CMS considers the following factors listed in 42 CFR § 424.519(f)(1) through (6):

“(1) The duration of the affiliation

- (2) Whether the affiliation still exists and, if not, how long ago it ended
- (3) The degree and extent of the affiliation
- (4) If applicable, the reason for the termination of the affiliation
- (5) Regarding the affiliated provider/supplier's disclosable event [under § 424.519(b)]:
 - (i) The type of disclosable event.
 - (ii) When the disclosable event occurred or was imposed.
 - (iii) Whether the affiliation existed when the disclosable event occurred or was imposed.
 - (iv) If the disclosable event is an uncollected debt: (A) the amount of the debt; (B) whether the affiliated provider or supplier is repaying the debt; and (C) to whom the debt is owed.
 - (v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.
- (6) Any other evidence that CMS deems relevant to its determination.”

2. Definition of Affiliation

For purposes of § 424.519 only, 42 CFR § 424.502 defines “affiliation” as:

- A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
- A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.
- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of [§ 424.519 only], sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization.
- An interest in which an individual is acting as an officer or director of a corporation.
- Any reassignment relationship under § 424.80.”

(NOTE: Concerning (a)(19), PEOG -- rather than the contractor -- will make all determinations regarding whether a provider/supplier has an affiliation per § 424.519 that poses an undue risk of fraud, waste, and abuse.)

S. Revocation Reason 20 – Billing from a Non-Compliant Location (42 CFR § 424.535(a)(20))

“CMS may revoke a provider's or supplier's Medicare enrollment or enrollments, even if all the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. In determining whether and how many of the provider/supplier's

enrollments (involving the non-compliant location or other locations) should be revoked, CMS considers the following factors [enumerated in § 424.535(a)(20)(i) through (vii)]:

- The reason(s) for and the specific facts behind the location's non-compliance;
- The number of additional locations involved;
- The provider or suppliers possibly history of final adverse actions or Medicare or Medicaid payment suspensions;
- The degree of risk the location's continuance poses to the Medicare Trust Funds;
- The length of time that the location was considered non-compliant;
- The amount that was billed for services performed at or items furnished from the non-compliant location; and,
- Any other evidence that CMS deems relevant to its determination."

(NOTE: Concerning (a)(20), PEOG – rather than the contractor – will make all determinations regarding whether a provider/supplier has performed services or furnished items from a location that did not comply with Medicare enrollment requirements.)

T. Revocation Reason 21 – Abusive Ordering, Certifying, Referring, or Prescribing of Part A or B Services, Items or Drugs (42 CFR § 424.535(a)(21))

"The physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements." In making its determination, CMS considers the following factors [enumerated in § 424.535(i) through (ix)]:

- Whether the physician or eligible professional's diagnosis supports the order, certification, referral or prescription in question;
- Whether there are instances where the necessary evaluation of the patient for whom the order, certification, referral or prescription could have not occurred (for example: the patient was deceased or out of state at the time of the alleged office visit);
- The number and types of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state(s) in which the individual practices and the reason(s) for the action(s);
- Whether the physician or eligible professional has any history of final adverse actions (as defined by 42 CFR § 424.502);
- The length of time over which the pattern or practice has continued;
- How long the physician or eligible professional has been enrolled in Medicare;
- The number of type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that resulted in a final judgement against the physician or eligible professional or the physician or

eligible professional paid a settlement to the plaintiff(s) (to the extent this can be determined);

- Whether any State Medicaid Agency (SMA) or other public health insurance program has restricted, suspended, revoked or terminated the physician's or eligible professional's ability to practice medicine and reason for any such restriction, suspension, revocation or termination; and
- Any other information that CMS deems relevant to its determination.

(NOTE: Concerning (a)(21), PEOG – rather than the contractor – will make all determinations regarding whether a physician or eligible professional has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items, or drugs that is abusive, threatening to the safety of Medicare beneficiaries, or fails to meet Medicare requirements).

U. Revocation Reason 22 – Patient Harm (42 CFR § 424.535(a)(22))

The physician or other eligible professional has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a revocation is appropriate, CMS considers the following factors [enumerated in § 424.535(a)(22)(i)(A) through (E)]:

(A) The nature of the patient harm.

(B) The nature of the physician's or other eligible professional's conduct.

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the state oversight board, IRO, federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(i) License restriction(s) pertaining to certain procedures or practices.

(ii) Required compliance appearances before State medical board members.

(iii) License restriction(s) regarding the ability to treat certain types of patients.

(iv) Administrative or monetary penalties.

(v) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician/other eligible professional's conduct and the degree of harm thereto or impact upon.”

(Per 42 CFR § 424.535(a)(22)(ii), paragraph (a)(22) does not apply to actions or orders pertaining exclusively to either of the following:

- Required participation in rehabilitation or mental/behavioral health programs; or

- Required abstinence from drugs or alcohol and random drug testing.)

V. Revocation Reason 23 – Standard or Condition Violation (42 CFR § 424.535(a)(23))

- (i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g).
- (ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).
- (iii) The opioid treatment program is non-compliant with any provision in § 424.67(b) or (e).
- (iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).
- (v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (c).

(All revocations based wholly, or in part, on § 424.535(a)(23) shall be sent to PEOG to obtain approval of both the revocation action itself and the revocation letter.) The contractor's revocation letter shall cite the exact statutory and/or regulatory citation(s) containing the specific standard/condition with which the provider/supplier is non-compliant. For a listing of some of these statutes and regulations, refer to section 10.2 et seq. of this chapter.)

(See section 10.4.7.5(A) for more information regarding § 424.535(a)(23).)

W. Extension of Revocation

If a provider's Medicare enrollment is revoked under § 424.535(a), CMS may revoke any and all of the provider's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types. In determining whether to revoke a provider's other enrollments, CMS considers the following factors:

- (i) The reason for the revocation and the facts of the case;
- (ii) Whether any final adverse actions have been imposed against the provider or supplier regarding its other enrollments;
- (iii) The number and type(s) of other enrollments; and
- (iv) Any other information that CMS deems relevant to its determination.

10.4.8 – Deactivations

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Deactivations of Enrollment/Billing Privileges

1. 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(A)(2)(a) and (c) below for more information on this 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)(2).)

(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. CMS particularly reiterates that – consistent with existing policy -- the contractor shall not on its own volition deactivate any provider/supplier for non-billing under § 424.540(a)(1). All § 424.540(a)(1) deactivations can only be implemented at CMS' explicit direction.

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

a. 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 *or adverse legal history* 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(A)(2)(c) 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(A)(2)(c) 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/supplier is the seller in an HHA, *hospice, or DMEPOS supplier* change in majority ownership under, *as applicable*, § 424.550(b)(1) or § 424.551.

b. Effective Dates

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

The effective dates of a deactivation are as follows:

- i. 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.
- ii. Section 424.540(a)(2), (3), and (4) (see subsection (A)(2)(a) 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. *For example, suppose a provider has a new 10 percent owner as of May 1 and, per § 424.516, must report the change within 30 days – that is, by May 31. The provider fails to do so. The deactivation effective date is the date on which the provider became non-compliant, or June 1.*
- iii. 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.
- iv. 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.
- v. 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.
- vi. 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 10.4.8(A)(2)(e)* below.)

(See subsection 10.4.8(A)(2)(d) below for additional information on § 424.540(a)(7). See subsection 10.4.8(A)(2)(e) below for additional information on § 424.540(a)(8).

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

(This section 10.4.8(A)(2)(c) is inapplicable to the situations described in section 10.4.8(A)(1)(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.

d. 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.

e. Section 424.540(a)(8)

See sections 10.6.1.1.5 *and* 10.6.1.1.6 of this chapter for information regarding seller CHOWs.

f. Miscellaneous

i. 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.

ii. 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.

iii. 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.

B. Deactivation of Ability to Order/Certify/Refer Certain Services or Items

Under § 424.547, CMS may deactivate a physician's or practitioner's ability to order, certify, or refer the Medicare services and items identified in § 424.507(a) and (b) if the individual:

- Is enrolled via the Form CMS-855O application solely to order, certify, or refer Medicare services or items; and*
- Has not been listed as the ordering, certifying, or referring individual on a Medicare Part A or B claim received in the previous 12 consecutive months.*

For purposes of § 424.547 only, the term "deactivate" means that the physician's or practitioner's ability to order, certify, or refer Medicare services or items has been stopped but can be restored upon the submission of updated information. While deactivated under § 424.547, the physician or practitioner may not order, certify, or refer the Medicare services or items described in § 424.507(a) and (b).

As a prerequisite for reactivating the ability to order, certify, or refer the services/items in § 424.507(a) and (b), the physician/practitioner must complete all sections of the submitted Form CMS-855O and check the "You are enrolling for the sole purpose of

ordering/certifying” box in Section I(A). The contractor shall process the application under (i) the “limited” screening level and (ii) the applicable timeframes for Form CMS-855O initial applications.

The effective date of reactivation is the date on which the contractor received the individual's reactivation submission that was processed to approval.

All deactivations under § 424.547 will be initiated by PEOG; the contractor shall not impose a § 424.547 deactivation on its own volition. If PEOG decides to deactivate an individual on this ground, it will notify the contractor, which shall then proceed with the deactivation using the procedures in this chapter similar to those for enrollment deactivations (e.g., sending applicable deactivation letter, switching the Form CMS-855O enrollment record to “Deactivated”). Regarding the letter, the contractor shall: (1) use the model in section 10.7.12(B); and (2) ensure it contains sufficient details – which PEOG will provide to the contractor – to clearly explain why the deactivation occurred. (Prior PEOG approval of the letter is not required.) The contractor shall send the notification letter via hard-copy mail and via e-mail (if a valid email address is available); the contractor shall 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.

The contractor shall complete all the forgoing steps associated with the deactivation no later than 7 calendar days after receiving direction from PEOG to deactivate the individual.

10.4.8.2 – Rebuttals for Ordering/Certifying Deactivations (Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Background and Contractor Functions

As noted in section 10.4.8(B) above, CMS under § 424.547 may deactivate a physician's or practitioner's ability to order, certify, or refer the Medicare services and items identified in § 424.507(a) and (b) if the individual:

- Is enrolled via the Form CMS-855O application solely to order, certify, or refer Medicare services or items; and
- Has not been listed as the ordering, certifying, or referring individual on a Medicare Part A or B claim received in the previous 12 consecutive months.

Consistent with the general principles of § 424.546, a physician or practitioner deactivated under § 424.547 may file a rebuttal. A rebuttal is an opportunity for the individual to demonstrate that the ability to order/certify should not have been deactivated. Only one rebuttal request may be submitted per deactivation. Additional rebuttal requests submitted for the same deactivation for which a rebuttal has already been received shall be dismissed.

The Division of Provider Enrollment Appeals within the Provider Enrollment & Oversight Group (PEOG) will handle all rebuttals related to a § 424.547 deactivation. (The deactivation notification letter will instruct the physician/practitioner to send its rebuttal directly to CMS/PEOG.) This includes, but is not limited to, notifying the physician/practitioner and the contractor of its receipt of the rebuttal, sending the decision letter to the physician/practitioner, and notifying the contractor of the decision.

Should the contractor inadvertently receive a § 424.547 deactivation rebuttal (even if it was untimely submitted), it shall forward it to ProviderEnrollmentAppeals@cms.hhs.gov no later than 10 calendar days after receipt and without taking any other action regarding the rebuttal.

If the contractor receives a reactivation or change of information application for a § 424.547 deactivated physician or practitioner during the 15-day rebuttal submission timeframe or while a rebuttal decision is pending, the contractor shall:

- *Notify CMS via ProviderEnrollmentAppeals@cms.hhs.gov about the submission; and*
- *Await CMS direction on how or whether to process the Form CMS-855O submission at this time. (The contractor may apply a clock stoppage.)*

The contractor shall provide PEOG with any information the latter requests for its review of the rebuttal. The information shall be furnished within 10 calendar days of the request.

If PEOG's rebuttal decision requires the contractor to take action on the physician's/practitioner's Form CMS-855O enrollment (e.g., reactivating the enrollment and thus the ability to order/certify), the contractor shall complete all such updates within 10 business days of the date of the rebuttal decision. This includes returning 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-855O is not needed."

If the decision is unfavorable for the physician/practitioner, no action by the contractor is needed unless the individual had submitted a reactivation application after being deactivated, in which case the contractor can begin processing it normally.

B. Rebuttal Submissions

1. Requirements and Submission of Rebuttals

Consistent with 42 CFR § 424.546(b), to be accepted and processed, the rebuttal submission must:

- (1) Be in writing;*
- (2) Specify the facts or issues concerning the deactivation with which the physician or practitioner disagrees, and the reasons for disagreement;*
- (3) Include all documentation and information the physician or practitioner 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 physician or practitioner 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 the attorney has the authority to represent the physician/practitioner; this statement is sufficient to constitute notice of such authority.*
 - *If the legal representative is not an attorney, the physician/practitioner 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 physician/practitioner or a legal representative.*
 - *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.

- (5) Be received by CMS within 15 calendar days from the date of the deactivation notice. The rebuttal can be submitted via hard-copy mail, e-mail, and/or fax.*

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 CMS received it by the next business day.

The CMS 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 physician's/practitioner'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. It is the physician's/practitioner's responsibility to timely update the enrollment record to reflect any changes to enrollment information (e.g., correspondence address).

3. Development for Rebuttal Submissions

If a rebuttal submission does not meet either of the following requirements, CMS will develop with the physician or practitioner before dismissing the rebuttal:

- State the facts or issues concerning the rebuttal with which the physician or practitioner disagrees, and the reasons for disagreement*
- Be signed and dated by the physician or practitioner or a legal representative*

The CMS will allow 15 calendar days from the date of the development letter for the rebuttal submitted to respond to the development request. If CMS does not receive an acceptable rebuttal after 15 calendar days, CMS will dismiss the rebuttal.

C. No Further Review

Consistent with 42 CFR § 424.546(f), a decision made regarding a rebuttal request is not an initial determination and is not subject to further review. No additional appeal rights will thus be included in any rebuttal decision letter.

10.4.9 – Stay of Enrollment

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(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

A stay of enrollment (or simply “stay”) *under § 424.541* 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. *(This includes situations where its change of information or revalidation application was rejected under § 424.525(a)(1) or (2).)*

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 *(or had its revalidation application rejected) and the 90-day period for responding to the revalidation request has expired.*
- A DMEPOS supplier did not report the deletion of a managing employee.
- A physician did not timely report a change in a 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 a 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 *and Effective Date* of the Stay (§ 424.541(a)(3))

A stay of enrollment lasts no longer than 60 days from *its effective date, which is, as applicable and except as otherwise stated in this section 10.4.9, one of the following under § 424.541(a)(3)*:

- *The date on which the provider's or supplier's non-compliance began; or*
- *The date on which the provider's change of information or revalidation application was rejected under 424.525.*

(The prior instruction that the effective date of the stay is the postmark date of the stay notification letter no longer applies except as otherwise noted.)

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:

- *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.

- *A provider receives a joint rejection-stay notification letter on June 1 because the contractor finds grounds to reject its revalidation application. The provider submits another revalidation application (which constitutes the ACF) on June 15. The stay ends on that day.*

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

- Adverse Action - A stay is not considered an adverse legal action of any kind.
- Deactivations and Revocations - **CMS always reserves the right to impose:**
 - 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.**
 - A deactivation prior to the expiration of the stay, in which case the deactivation ends the stay**
- 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).
- 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.
- 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
 - *Changes of ownership (CHOWs)*
- 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).**
- 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 *or revalidation application rejections* (see subsection (D) 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.
- i. Revalidation Application Rejections and Associated Stay Effective Dates – *For purposes of the stay of enrollment concept, rejections of revalidation applications shall be treated largely similarly to revalidation non-responses. This is particularly true with respect to timing, in that in both situations a stay cannot be imposed until the expiration of the 90-day revalidation response period.*

Assume the contractor sends a revalidation request to the provider on April 1 with a due date of June 30:

(A) The provider submits the application on June 15. The application is rejected on July 31. The contractor can impose a stay at this time because the 90-day revalidation period has expired.

(B) The provider submits the application on April 15. The application is rejected on May 31. The contractor cannot impose a stay until July 1. If, between June 1 and June 30, the provider:

(1) Submits another revalidation application that is processed to approval, no stay shall be imposed -- even if the approval came after the original 90-day period expired (e.g., the contractor received the second revalidation application on June 15 and approved it on July 31, 120 days after the commencement of the original revalidation period on April 1).

(2) Submits another revalidation application that the contractor rejects, the contractor can impose a stay if the 90-day period has expired. If it has not, the contractor must wait until it does.

(3) Fails to submit another revalidation application, the contractor can impose a stay on July 1 since the 90-day period has expired.

6. General Stay Process for Revalidation *Non-Responses or Application Rejections*

In general – and subject to the more specific scenarios described in section 10.4.9(D) -- the stay process will work as follows in situations where: (i) *the provider fails* to submit a revalidation application in response to a CMS/contractor revalidation request; *or (ii) the provider's revalidation application is rejected.*

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 applicable* letter identified in section 10.7.20; and (b) switch the PECOS status to “Approved – Stay of Enrollment”.

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 generally 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 applicable letter identified in section 10.7.20; and (b) switch the PECOS status to “Approved – Stay of Enrollment” *effective February 28 (the day after the RRT expired). This means Smith has until March 29* (or 30 days) to submit the revalidation application. Claims for services furnished beginning *February 28* 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. *Using our example in the previous paragraph, suppose Smith submits its revalidation on March 3, before the contractor sends the stay notification letter. The contractor can forgo imposing a stay even though Smith was out of compliance between February 28 and March 2.*)

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 *February 28* 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 *March 29*, 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 *March 29* date (i.e., by April 8), 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 *March 30* 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 (*February 28 – March 29*) 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: (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 March 29.*)

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

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.

Scenario E - Contractor Imposes Stay for Failure to Submit Requested Revalidation Application and Provider Then Submits COI Rather Than Revalidation. Here, the contractor:

- (i) Shall not remove the stay. This is because the COI is not an ACF --- that is, it does not address the cause of the stay, which is the failure to submit a revalidation application.
- (ii) Shall follow the instructions in section 10.4.5.1(C) of Chapter 10 with respect to the COI submission.
- (iii) Shall develop for a revalidation application via any written means (e.g., e-mail but not telephone). The provider shall have 30 additional days from the date the contractor

received the COI to submit the revalidation application. In no circumstance, however, shall this latter revalidation timeframe exceed 60 days from the effective date of the stay. To illustrate, suppose the stay's effective date is June 1. The contractor receives the COI on July 2 before it proceeds to a deactivation. (See Scenario D of section 10.4.9(D)(1).) The provider has until July 31 (rather than August 1) to submit the revalidation 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 *that CMS directs (or, if no date was directed, the date the stay notification letter was 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 *on the stay effective date that CMS directed (or, if no date was directed, 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 *on the stay effective date that CMS directed (or, if no date was directed, 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. *Per CMS direction, the stay is effective July 30 (the date the provider's non-compliance began), is for 30 days, and thus ends on August 29.* Provider X fails to submit the ACF during that period. The contractor must complete Step 3 *by September 3 (rather than September 8)*. 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 stay effective date that CMS directed (or, if no date was directed, the date the stay notification letter was mailed)*.

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 that CMS directs (or, if no date was directed, the date the stay notification letter was 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 *on the stay effective date that CMS directed (or, if no date was directed, 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 *on the stay effective date that CMS directed (or, if no date was directed, 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) *(including -- as indicated in section 10.4.1.4.3(E)(1)(a) -- situations where the provider's/supplier's CHOW or change of information submission is rejected)*, 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.

d. Additional Case Studies Where PEOG Directs a Stay

This subsection (D)(2)(d) identifies certain scenarios in which PEOG may direct a stay and how the contractor should handle the situation. These scenarios are in addition to, and not in lieu of, others that are addressed in section 10.4.9(D).

(i) ACF Received Before the Stay's Imposition

Assume CMS instructs the contractor to impose a stay in Instance (D)(2)(a), (b), or (c) above. Before the contractor mails the stay notification letter to the provider, however, the contractor receives the ACF (as the term ACF is defined/explained in this section 10.4.9). Here:

1. The contractor shall not impose the PEOG-directed stay and shall instead process the ACF normally (including development as needed).
2. Notwithstanding the language in the opening paragraph of subsection (D)(2) regarding PEOG notification, the contractor shall inform its PEOG BFL via e-mail that the stay was not implemented and why. This e-mail shall be sent no later than 7 calendar days after the contractor received the ACF.

(ii) ACF Submitted During the Stay

Assume Scenario (D)(2)(d)(i) above but further assume that the provider submits the ACF after the stay is implemented. Here, the contractor shall generally follow Step 3 in Scenario A of subsection (D)(1) – specifically: (1) change the PECOS status to “Approved – Remove Stay of Enrollment” effective on the submission date; and (2) process the ACF normally (including development as needed).

If the ACF is approved, the contractor shall generally follow Step 4 in Scenario A of subsection (D)(1).

If the ACF is rejected, the contractor shall follow Step 5 in Scenario C of subsection (D)(1) (though -- as applicable depending on the type of stay involved (e.g., ownership discrepancy) -- modified as described in subsection (D)(2)(a), (b), or (c)) Note that in Step 5, the stay does not go back into effect when the application is rejected and then remain intact until the originally assigned stay period (e.g., 30 days) expires. Rather, the contractor (as described in Step 5) shall proceed to a deactivation without reimposing the stay.

(iii) Contractor Receives COI Before Mailing the Stay Notification Letter

(a) The submitted COI is an ACF, meaning -- as explained in section 10.4.9(B) -- it can remedy the non-compliance in question via the form submission. Here:

- (1) The contractor shall not impose the stay and shall instead process the ACF normally (including development as needed).
- (2) Notwithstanding the language in the opening paragraph of subsection (D)(2) regarding PEOG notification, the contractor shall inform its PEOG BFL via e-mail that the stay was not implemented and why. This e-mail shall be sent no later than 7 calendar days after the contractor received the ACF.

(b) The submitted COI is **not** an ACF. Here:

- (1) The contractor shall impose the stay as directed, using the procedures outlined in section 10.4.9.
- (2) The contractor shall develop the COI for the information that will remedy the non-compliance (i.e., the missing/deficient/incorrect ACF data that triggered the stay directive). This means the ACF information, to the maximum extent possible, should be furnished on/via the COI and not through a separate ACF submission. However,

the contractor shall accept and process the ACF if it is submitted separate from the COI; in this situation, the contractor shall merge the COI and ACF into a single submission. Note that the processing time clock does not stop when developing the COI for the ACF data.

- (3) In its stay notification letter – which, for purposes of this scenario, will also constitute a development letter -- the contractor shall request that the provider update its COI with the ACF. (The specific verbiage lies within the contractor’s discretion.) If the COI itself also requires development (e.g., data is incorrect), the letter shall also explain the information to be added, remedied, etc.
- (4) Consistent with current policy (assuming the designated stay period (e.g., 30 days) has not expired), the stay ends on the date the provider submits the ACF – either via an update to the COI or as a separate submission.
- (5) Final determination
 - If the submitted ACF data cannot be approved (irrespective of whether the COI data can), the contractor shall proceed to a deactivation consistent with the instructions in subsection (D)(2). The COI data will ostensibly be captured via the provider’s reactivation application.
 - If the submitted ACF data can be approved but the COI information cannot, the contractor shall contact its PEOG BFL for guidance on how the matter should be handled.

E. Returns

In any situation where the contractor determines the submitted ACF – be it a revalidation, COI, etc. -- should be returned, the contractor shall treat the matter as it would a rejected ACF. (See Steps 4 and 5 of Scenario C of subsection (D)(1).)

F. 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.

G. 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.**

H. Rebuttals

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

I. 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.

J. Stay Expires – Deactivation Effective Date

To reiterate, if a stay expires and a deactivation immediately follows, the deactivation effective date is the date on which the provider first became non-compliant. This is consistent with the guidance in section 10.4.9(D).

K. Removal of A/R Code

As indicated in section 10.4.9, the contractor shall remove the stay of enrollment (e.g., A/R 350 or the Part A PARM) from the provider’s file upon:

- Deactivation of the enrollment if the provider did not submit an ACF during the stay period.
- Submission of the ACF after the stay period has ended but prior to deactivation.

(Other situations when the stay should be lifted are addressed in section 10.4.9.)

10.6.1.1.6 – DMEPOS Supplier Change in Majority Ownership (Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

Note that section 10.6.1.1.6 negates the longstanding general rule that a DMEPOS supplier change of ownership resulting in a new tax identification number (TIN) requires the submission of an initial application and enrollment as a new DMEPOS supplier. All ownership changes are now governed by § 424.551. Accordingly, even in situations where an ownership change results in a new TIN, a new initial application is unnecessary if § 424.551 does not apply.

A. Background – 36-Month Rule

1. General Principles

In accordance with 42 CFR § 424.551, if there is a change in majority ownership of a DMEPOS supplier by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the DMEPOS supplier’s initial enrollment in Medicare or within 36 months after the DMEPOS supplier’s most recent change in majority ownership, the supplier’s Medicare billing privileges do not convey to the new owner. The prospective supplier/owner of the DMEPOS supplier must instead:

- ***Enroll in the Medicare program as a new (initial) DMEPOS supplier, and***
- ***Undergo a survey by, and obtain a new accreditation from, a CMS-approved DMEPOS accrediting organization in accordance with §§ 424.57 and 424.58.***

For purposes of § 424.551, a “change in majority ownership” occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a DMEPOS supplier during the 36 months following the DMEPOS supplier’s initial enrollment in the Medicare program or the 36 months following the DMEPOS supplier’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 a DMEPOS supplier 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 DMEPOS supplier's most recent change in majority ownership.

2. Exceptions

There are several exceptions to § 424.551. Specifically, the requirements of § 424.551 do not apply if:

- The DMEPOS supplier's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.
- The DMEPOS supplier 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 DMEPOS supplier dies.

In addition, § 424.551 does not apply to “indirect” ownership changes. For purposes of the 36-month rule's application, an indirect owner is a party that owns a direct or indirect owner of the DMEPOS supplier. Consider the following illustrations:

EXAMPLE 1: Smith DMEPOS Supplier is established as a corporation. It is listed as the supplier in Section 2 of the Form CMS-855S. The corporation has four shareholders (W, X, Y, and Z), each of which own 25% of Smith. Since Smith is the enrolling supplier and W, X, Y, Z own Smith's stock, W, X, Y, and Z are considered direct owners of Smith. Thus, if W, X, and Y sell their 25% shares to Jones, Jones now directly owns 75% of Smith. A change in majority enrollment under § 424.551 has occurred.

EXAMPLE 2: Smith DMEPOS Supplier is established as an LLC. It is listed as the supplier in Section 2 of the Form CMS-855S. The LLC has two owners, Company X and Company Y. X owns 80% of Smith, and Y owns 20%. X and Y are accordingly direct owners of Smith. Company Z owns 100% of X, making Z an indirect owner of Smith. Now suppose that Company V purchases Z in its entirety. Since the transaction involves a sale of one of Smith's indirect owners, § 424.551 is not invoked.

DMEPOS suppliers should not assume that – using Example 1 above: (1) the corporation is the direct owner of Smith; (2) W, X, Y, and Z were therefore merely indirect owners of Smith; and (3) the sale of W/X/Y's shares to Jones is an indirect ownership change that does not trigger the 36-month rule. To the contrary, the corporation – as Smith DMEPOS Supplier – IS the supplier, hence making W/X/Y/Z direct owners of Smith.

3 Timing of 36-Month Period for DMEPOS Supplier

The provisions of 42 CFR § 424.551 with respect to DMEPOS suppliers (as promulgated in the CY 2026 Home Health Prospective Payment System (HH PPS) final rule) are effective January 1, 2026. This means these provisions impact only those DMEPOS ownership transactions whose effective date is on or after January 1, 2026. However, the provisions can apply irrespective of when the DMEPOS supplier enrolled in Medicare or had its most recent previous change in majority ownership, as shown in the following:

- Example 1 – Smith DMEPOS Supplier initially enrolled in Medicare effective February 1, 2024. It undergoes a change in majority ownership effective February 1, 2026. The provisions of § 424.551 apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

- *Example 2 – Jones DMEPOS Supplier initially enrolled in Medicare effective February 1, 2022. It undergoes its first change in majority ownership effective October 1, 2025. Section 424.551 does not apply to this transaction because it occurred: (i) more than 36 months after Jones’s initial enrollment; and (ii) prior to January 1, 2026. Suppose, however, that Jones undergoes another change in majority ownership effective February 1, 2027. Section 424.551 applies to this transaction because it took place on/after January 1, 2026, and within 36 months after Jones’s most recent change in majority ownership (i.e., on October 1, 2025).*
- *Example 3 – Davis DMEPOS Supplier initially enrolled in Medicare effective February 1, 2025. It undergoes its first change in majority ownership effective February 1, 2029. This change would not be affected by § 424.551 because it occurred more than 36 months after Davis’s initial enrollment. Davis undergoes another change in majority ownership effective February 1, 2033. This change, too, would be unaffected by § 424.551, for it occurred more than 36 months after the supplier’s most recent change in majority ownership (i.e., on February 1, 2029). Davis undergoes another majority ownership change on February 1, 2035. This change would be impacted by § 424.551, since it occurred within 36 months of the supplier’s most recent change in majority ownership (i.e., on February 1, 2033).*

B. Determining the 36-Month Rule’s Applicability

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

Step 1 – Change in Majority Ownership

Based on the information furnished on the Form CMS-855S, the supplier’s existing enrollment record and the bill of sale/sales agreement, the contractor shall determine whether a change in direct majority ownership has occurred. This includes verifying 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 DMEPOS supplier.*

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 DMEPOS supplier, this would constitute a change in majority ownership. This is consistent with the verbiage in the above-mentioned 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 0.1 percent ownership stake, the owner 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.

Note that DMEPOS suppliers must submit with their Form CMS-855S a copy of the bill of sale or sale/transfer agreement for all ownership changes, regardless of the percentage involved (e.g., new 15 percent owner). (The Form CMS-855A contains a similar requirement.) If the supplier does not include the bill of sale/sale-transfer agreement with its Form CMS-855S submission, the contractor shall request it. However - and unless CMS directs otherwise - the contractor need only review the bill of sale/sales-transfer agreement for purposes of determining whether the 36-month rule applies.

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 DMEPOS supplier'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 sales/transfer 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 DMEPOS supplier – regarding the effective date of the DMEPOS supplier's most recent change in majority ownership, if applicable.

If the transfer's effective date does not fall within either of the aforementioned 36-month periods, the contractor may process the submission normally.

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 § 424.551 (cited in subsection (A)(2) above) apply. This can be done by reviewing the sales/transfer agreement, bill of sale, etc.

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. 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 DMEPOS supplier and require an initial enrollment based thereon without the prior approval of PEOG. If PEOG agrees with the contractor's determination:

(1) The contractor shall identify the voluntary termination action in PECOS as a deactivation --- and hence shall deactivate the DMEPOS supplier'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 date of the sale shall be the effective date of the deactivation.

(2) The contractor shall send to the DMEPOS supplier the "36-Month Rule Voluntary Termination Letter" in section 10.7.21. This letter will include, among other things, rebuttal rights regarding the deactivation as well as language stating that, as a result of § 424.551, the DMEPOS supplier must:

- *Enroll as an initial applicant; and*
- *Obtain a new survey and accreditation by a CMS-approved DMEPOS accreditation organization.*

The contractor shall copy the DMEPOS supplier's accreditation organization on the letter.

(3) The DMEPOS supplier need not submit a Form CMS-855S voluntary termination application.

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

C. Additional Notes

The contractor is advised of the following:

- 1. If the contractor learns of a DMEPOS supplier ownership change by means other than the submission of a Form CMS-855S application, it shall notify its PEOG BFL immediately.*
- 2. If the contractor determines, under Step 3 above, that one of the § 424.551 exceptions is applicable, the ownership sale still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that a DMEPOS supplier initially enrolled in Medicare effective July 1, 2023. It undergoes a change in majority ownership effective February 1, 2025. The contractor determines that the transaction is exempt from § 424.551. On February 1, 2027, the DMEPOS supplier undergoes another change in majority ownership, but no exception applies. The DMEPOS supplier must enroll as a new DMEPOS supplier under § 424.551 because the transaction occurred within 36 months of the supplier's most recent change in majority ownership - even though the February 2025 change was exempt from § 424.550(b)(1).*

10.6.2 – Establishing Effective Dates

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

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

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

A. Date of Enrollment/Approval

This section 10.6.2(A) does not apply to the application of § 424.535(g)(3). See section 10.4.7.2(A)(3) for more information.

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

practitioner submits a Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1.

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

1. Applicability

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

- a. Physicians; physician assistants; nurse practitioners; audiologists; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; independently billing psychologists, registered dietitians or nutrition professionals; physical therapists; occupational therapists; speech-language pathologists; mental health counselors; marriage and family therapists; and physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above.
- b. Ambulance suppliers
- c. Part B hospital departments
- d. CLIA labs
- e. Opioid treatment programs.
- f. Mammography centers
- g. Mass immunizers/pharmacies
- h. Radiation therapy centers
- i. Home infusion therapy suppliers

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

2. Background

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

- (i) The date the supplier filed an enrollment application that was subsequently approved, or
- (ii) The date the supplier first began furnishing services at a new practice location.

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

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

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

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

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

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

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

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

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

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

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

C. Effective Date of Reassignment

Consistent with 42 CFR § 424.522(a), the effective date of *a reassignment is the later of the dates in § 424.520(d)(1)(i) and (ii) (identified above in section 10.6.2(B)(2)). Moreover, as stated in § 424.522(b), the individuals and organizations identified in § 424.521(a)(2) may retrospectively bill for services in accordance with the reassignment if the requirements of § 424.521(a)(1) are met. (See section 10.6.2(B)(3) above).*

As noted elsewhere in this chapter, individual physicians and practitioners who wish to reassign *benefits* must now complete Section 4(F) of the Form CMS-855I rather than the discontinued Form CMS-855R. With this, the following scenario occasionally arises:

- (1) The physician or practitioner submits a Form CMS-855I to reassign *benefits*;
- (2) Section 4(F) is either blank or incomplete;

- (3) The contractor develops for a completed Section 4(F); and
- (4) The physician or practitioner submits Section 4(F).

The reassignment effective date in this situation -- assuming the application and Section 4(F) are ultimately approved and all applicable requirements were met during this timeframe -- should be based on the date on which the Form CMS-855I was initially submitted and not the date on which the physician or practitioner finally submitted Section 4(F). For instance, suppose a reassigning physician submits a Form CMS-855I on March 1 with Section 4(F) incomplete. The physician later submits Section 4(F) on March 14. The reassignment effective date is predicated on the March 1 date and not March 14. This means that the extra 30-day or 90-day period goes back from March 1.

The policies in this section 10.6.2(C) apply to: (1) initial reassignments as part of an initial enrollment; and (2) enrolled suppliers that are adding a new reassignment.

D. Effective Date for Certified Providers and Certified Suppliers

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

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

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

- (1) The supplier has submitted a completed application to CMS to furnish Medicare-covered items including required enrollment forms. (The supplier must enroll separate physical locations it uses to furnish Medicare-covered DMEPOS excluding locations that it uses solely as warehouses or repair facilities.)
- (2) The item was furnished on or after the date CMS issued to the supplier a DMEPOS supplier number conveying billing privileges. (CMS issues only one supplier number for each location.) This requirement does not apply to items furnished incident to a physician's service.

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

F. Form CMS-855O Effective Dates

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

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

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

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

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

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

H. Future Effective Dates

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

10.7.12 – Deactivation Model Letters

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

(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.)

A. Deactivation of Billing Privileges (§ 424.540)

[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:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicare billing data and found that you have not submitted any Medicare claims in more than [six or twelve] consecutive calendar months prior to 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 Smith is deceased as of January 1, 2017. Your Medicare enrollment application, signed and certified on November 1, 2016, identifies 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 the reassigned provider's/supplier's 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 the attorney has the authority to represent the provider/supplier.

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

The rebuttal should be sent to the following:

[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]

B. Deactivation of Ordering/Certifying Ability (§ 424.547)

[Month] [DD], [YYYY]

[Physician/Practitioner] (as it appears in PECOS)

[Address]

[City], [State] [Zip Code]

Re: Deactivation of Ability to Order/Certify Medicare Services and Items

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

NPI: [XXXXXXXXXX]

PTAN: [XXXXX]

Reference Number: [XXXX] (Internal Tracking)

Dear [Provider/Supplier Name]:

Your Medicare Form CMS-855O enrollment to solely order, certify, or refer the services and items described in 42 Code of Federal Regulations (C.F.R.) § 424.507(a) and (b) is being deactivated effective [Month] [DD], [YYYY] pursuant to 42 C.F.R. § 424.547.

[Explain the facts behind the deactivation. An example narrative could include:

CMS reviewed your Medicare ordering/certifying data and found that you have not been listed as the ordering, certifying, or referring individual on a Medicare Part A or B claim received in the previous 12 consecutive months. Accordingly, your Form CMS-855O enrollment and your ability to order, certify, or refer the services and items identified in § 424.507(a) and (b) are deactivated.]

REBUTTAL RIGHTS:

If you believe that this deactivation is not correct, you may submit a rebuttal consistent with the principles of 42 C.F.R. § 424.545(b). CMS must receive your written rebuttal 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*
- *Be signed by you or your representative*
 - *If your representative is not an attorney, you must send us a signed letter authorizing your representative to act on your behalf*
 - *If your representative is an attorney, the rebuttal must include a statement that the attorney is authorized to represent you*
- *Include any other information or documents you would like us to consider (such as updated applications)*

You may only submit one rebuttal in response to this deactivation of your Medicare enrollment.

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

Send your rebuttal to ProviderEnrollmentAppeals@cms.hhs.gov or mail to this address:

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

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]

10.7.15 – Revalidation Notification Letters

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

A. Revalidation Letter – Non-DMEPOS Supplier

REVALIDATION

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy]**. If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

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

Reassignments: <Only include this title if the record has any reassignments>

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

<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

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

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

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search [cms.gov](https://www.cms.gov) for “CR 7350” or “Fee Matrix”.

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If you need help

Visit go.cms.gov/MedicareRevalidation

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

Sincerely,

[Name]

[Title]

[Company]

B. Revalidation Letter – DMEPOS Supplier

REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every three years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice location.

We need this from you by [Due date, as Month dd yyyy]. If we do not receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier and your enrollment is deactivated, you will maintain your original PTAN. However, 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 by [Due date, as Month dd yyyy]
[Name] | NPI [NPI] | PTAN [PTAN]
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

The CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

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

- **Online:** PECOS is the fastest option. If you do not 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-855S] for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for “CR 7350” or “Fee Matrix”.

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if: (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data.

The current version of the form can be found at <http://www.cms.gov/Medicare/CMSForms/CMS-Forms/Downloads/CMS588.pdf>.

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name]
[Title]
[Company]

C. Revalidation Letter – CHOW Scenario Only

[month] [day], [year]

PROVIDER/SUPPLIER NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Name:

THIS IS A PROSPECTIVE PROVIDER ENROLLMENT REVALIDATION REQUEST

IMMEDIATELY SUBMIT AN UPDATED
PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM TO VALIDATE YOUR
ENROLLMENT INFORMATION

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the post mark date of this letter to submit complete enrollment information.

You previously submitted a change of ownership (CHOW) application that is currently being reviewed by the State Agency. Since your application has not been finalized, please validate that we have the most current information on file. Any updated information received since your initial submission will be forwarded to the State Agency for a final determination.

Providers and suppliers can validate their provider enrollment information using the paper application form. To validate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at <https://www.cms.gov/MedicareProviderSupEnroll/>. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

A new Electronic Funds Transfer (EFT) Authorization Form (CMS-588) is only required to be submitted as part of your revalidation package if (1) you have no Form CMS-588 on file with Medicare at all; or (2) you are changing any of your existing Form CMS-588 data. The current version of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>.

If additional time is required to complete the validation applications, you may request one 60-day extension, which will be added onto the initial 60 days given to respond to the request. The request may be submitted in writing from the individual provider, the Authorized or Delegated Official of the organization or the contact person and addressed to the MAC(s). The request should include justification of why a 60-day extension is needed. The request may also be made by contacting your MAC(s), via phone.

Physicians, non-physician practitioners and physician and non-physician practitioner organizations must report a change of ownership, any adverse legal action, or a change of practice location to the MAC within 30 days. All other changes must be reported within 90 days. For most but not all other providers and suppliers, *additions/changes in adverse legal actions* and of ownership or control, including changes in authorized official(s), must be reported *within 30 days; all other changes to enrollment information must be made within 90 days*. For all provider and supplier types, any change of practice location (including practice location additions, deletions, and relocations) must be reported within 30 days.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated and your CHOW not being processed. We strongly recommend you mail your documents using a method that allows for proof of receipt.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Sincerely,
[Your Name]
[Title]

D. Large Group Revalidation Notification Letter

[month] [day], [year]

PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Group Name:

THIS IS NOT A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within the next seven months. The physician or non-physician practitioner will need to respond by the revalidation due date provided for each provider. It is the responsibility of the physician /or non-physician practitioner to revalidate all the physician's or practitioner's Medicare enrollment information and not just that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]

[Title]

E. Revalidation Pend Letter

PAYMENT HOLD

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every [three or five years], CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

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

Reassignments:

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

<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

How to resume your payments

Revalidate your Medicare enrollment record, through

<https://pecos.cms.hhs.gov/pecos/login.do> or [form CMS-855 or Form CMS-20134].

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

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

If you need help

Visit [go.cms.gov/MedicareRevalidation](https://www.cms.gov/MedicareRevalidation)

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

Sincerely,

[Name]

[Title]

[Company]

F. Revalidation Deactivation Letter

STOPPING BILLING PRIVILEGES

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Your Medicare billing privileges are being deactivated effective [Month] [DD], [YYYY], pursuant to 42 C.F.R. § 424.540(a)(3) because you have not timely revalidated your enrollment record with us, or your revalidation application has been rejected because you did not timely respond to our requests for more information. We will not pay any claims after this date.

Every five years [three for DMEPOS suppliers], CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

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

Reassignments:

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

<Repeat for other reassignments>

CMS lists the records that need revalidating at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Rebuttal Rights:

If you believe that this determination is not correct, you may rebut the deactivation as indicated in 42 C.F.R. § 424.546. 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 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.) 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 the reassigned provider's/supplier's 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'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 the attorney has the authority to represent the provider/supplier.

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

The rebuttal should be sent to the following:

[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 a.m./p.m ET/MT/CT/PT] and [x:00 a.m./p.m ET/MT/CT/PT].

How to recover your billing privileges

Revalidate your Medicare enrollment record, through [PECOS.cms.hhs.gov](https://pecos.cms.hhs.gov), or [Form CMS-855 or Form CMS-20134].

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

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

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help Visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

Call [contractor telephone number] or visit [contractorsite.com] for more options.

Sincerely,

[Name]
[Title]
[Company]

G. Revalidation Past-Due Group Member Letter

REVALIDATION | Past-Due Group Member

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

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

Reassignments: <Only include this title if the record has any reassignments>

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

<Repeat for other reassignments>

The CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What your group member needs to do

Revalidate the member's 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 the member doesn't know the member's username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.
- **Paper:** Download the right version of [Form CMS-855 or Form CMS-20134] for the enrollment situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].

If your group member needs help

Visit go.cms.gov/MedicareRevalidation

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

Sincerely,

[Name]

[Title]

[Company]

H. Model Return Revalidation Letter

RETURN REVALIDATION

[month] [day], [year]

[Provider/Supplier Name]

[Address]

[City], [State] [Zip Code]

NPI: [xxxxxxxxxxx]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- The [Form CMS-855 or Form CMS-20134] application received by [PROVIDER/SUPPLIER NAME] was unsolicited.
 - An unsolicited revalidation is one that is received more than seven months prior to the provider/supplier's due date. Due dates are established around 5 years from the provider/supplier's last successful revalidation or initial enrollment.
 - To find the provider/suppliers revalidation due date, please go to <http://go.cms.gov/MedicareRevalidation>.
 - If you are not due for revalidation in the current seven-month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current seven-month period. This list will be updated monthly.
- If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the [form CMS-855 or Form CMS-20134].
- Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: <https://pecos.cms.hhs.gov/pecos/login.do>.
2. Paper application process: Download and complete the Medicare enrollment application(s) at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>.

If you need help

Visit <http://go.cms.gov/MedicareRevalidation>, or

Call 2 [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,

[Name]

[Title]
[Company]

10.7.20 – Stay of Enrollment Letters

(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)

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 or Rejection Stay of Enrollment

[month] [day], [year]

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

Dear [Provider/Supplier Name],

Pursuant to 42 *Code of Federal Regulations (CFR)* § 424.541, we are placing a stay on your Medicare enrollment record effective [*insert day after 90-day period expired*] because you have [*insert reason: “not responded to our revalidation request of [date revalidation request letter sent]” or “failed to timely respond to our request of [insert date of most recent request] for additional information regarding your revalidation application and the 90-day timeframe for submitting an acceptable revalidation application has expired.”*] Your revalidation was due on [insert date], *90 days after the date our revalidation request letter to you.*

[Insert following if application also to be rejected for failure to respond to development request: “In addition, we are rejecting your revalidation application. Under 42 CFR § 424.525, providers and suppliers are required to submit complete application(s) and all supporting documentation within 30 calendar days from the postmark date of the contractor request for missing/incomplete information.]

During this stay, claims for services and items you furnish during this period will be rejected. However, 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 the reassigned provider's/supplier's 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 the attorney 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:

[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]

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 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 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. However, 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]

How to resume your payments:

- **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 the reassigned provider's/supplier's 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'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 the attorney 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:

[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]

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]

C. Stay of Enrollment Rebuttal Model Letters

Instruction

For the following model letters, all text within parentheses is intended as instruction/explanation and should be deleted before the letter is finalized and sent to the provider/supplier. All text within brackets requires the contractor to fill in the appropriate text. All letters and emails shall be saved in PDF format. The date on the letter shall be the date it was sent to the provider/supplier.

1. Rebuttal Further Information Required Development Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Development Request
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (Optional)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD], [YYYY], [Contractor Name] issued a favorable rebuttal determination, reversing the stay of [Provider/Supplier Name]'s Medicare enrollment and billing privileges. As stated in the [Month] [DD], [YYYY] determination letter, the reinstatement of [Provider/Supplier Name]'s Medicare enrollment is contingent upon the submission of [list required documentation] (lists of 3 or more items should be in a bulleted list). Please send the required documentation to:

[Contractor Rebuttal Receipt Address]

[Contractor Rebuttal Receipt Email Address]

Fax: [Contractor Rebuttal Receipt Fax Number]

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[Contractor Name]

2. Rebuttal Facts or Issues and Reasons for Disagreement Development Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal]

[Address] (Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Development Request

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

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541. We received your rebuttal submission on [Month] [DD], [YYYY].

As stated in the stay of enrollment letter dated [Month] [DD], [YYYY], and 42 C.F.R. § 424.541(b), to be accepted and reviewed, your rebuttal must state the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. The rebuttal received on [Month] [DD], [YYYY] does not clearly identify the facts or issues with which you disagree and your reasons for disagreement. [Contractor Name] is granting you an additional 15 calendar days from the date of this notification letter to submit a proper rebuttal that clearly identifies the facts or issues with which you disagree and your reasons for disagreement. This revised rebuttal submission must be received within 15 calendar days of the date of this notice. If you do not timely respond to this request, [Contractor Name] may dismiss your rebuttal submission.

Please send the required documentation to:

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

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(4).

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

3. Rebuttal Withdrawn Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Withdrawal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

We are in receipt of your written request to withdraw your rebuttal received on [Month] [DD], [YYYY], submitted in response the stay of [Provider/Supplier]'s enrollment. [Contractor Name] has not yet issued a rebuttal determination. Therefore, [Contractor Name]

considers the rebuttal to be withdrawn. As a result, a determination will not be issued in response to the rebuttal and [Provider/Supplier Name]'s Medicare enrollment will remain subject to a stay of enrollment imposed under 42 C.F.R. § 424.541.

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under § 424.541(b)(4).

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

4. Rebuttal Receipt Acknowledgement Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

On [Month] [DD], [YYYY] we received your rebuttal regarding the stay of [Provider/Supplier Name]'s enrollment. The stay of enrollment was imposed by letter dated [Month] [DD], [YYYY]. [Contractor Name] will further review the information and documentation submitted in the rebuttal and will render a final determination regarding the stay of enrollment within 30 days of the date of receipt.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

5. Final Rebuttal Decision Email Template - Stay of Enrollment

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

To: [Email address provided by the person who submitted the rebuttal and email address listed in the provider/supplier correspondence mailing address on the enrollment application if different from the email address on the rebuttal submission.]

Subject: Medicare Stay of Enrollment Rebuttal re: [Provider/Supplier Name]

Dear [Name of the person(s) who submitted the rebuttal]:

Please see the attached determination regarding your rebuttal, in response to the stay of [Provider/Supplier Name]'s enrollment.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

6. Rebuttal Dismissal Model Letters - Stay of Enrollment

a. Untimely Rebuttal Dismissal Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal as it was not timely submitted. The stay of enrollment letter was dated [Month] [DD], [YYYY]. Pursuant to 42 C.F.R. § 424.541(b)(1), a rebuttal must be received within 15 calendar days of the date of the stay of enrollment letter. Your rebuttal was not received until [Month] [DD], [YYYY], which is beyond the applicable submission time frame. You failed to show good cause for the late request. Therefore, [Contractor Name] is unable to render a determination in this matter and the stay of enrollment will not be modified.

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(4).

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

b. Improper Signature Rebuttal Dismissal Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal because it did not contain any of the following:

1. Signature by an authorized or delegated official currently on file in [Provider/Supplier]'s Medicare enrollment, the individual practitioner or a legal representative;
2. The required statement of representation from an attorney;

3. Signed written notice appointing a non-attorney legal representative.

Please be advised that authorized or delegated officials for groups cannot sign and submit a rebuttal on behalf of a reassigned practitioner without a signed statement authorizing that individual from the group to act on the practitioner's behalf.

The signature requirement is stated in the [Month] [DD], [YYYY] stay of enrollment letter, and in 42 C.F.R. § 424.541(b)(3)(iv). Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you provide a properly signed rebuttal and permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.]

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15 calendar days. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.]

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b).

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[Contractor Name]

c. No Rebuttal Rights Rebuttal Dismissal Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal] (If submitted on behalf of an organization or group)

[Address](Address from which the rebuttal was sent)

[City], [State] [Zip Code]

Re: Rebuttal Submission Dismissal

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

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] on [Month] [DD], [YYYY], submitted on behalf of [Provider/Supplier Name].

[Contractor Name] is unable to accept your rebuttal submission because the action taken in regard to [Provider/Supplier]'s Medicare enrollment or billing privileges does not afford the opportunity for a rebuttal. Only a provider/supplier whose enrollment is stayed under 42 C.F.R. § 424.541, or whose billing privileges are deactivated under § 424.540 may file a rebuttal. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.

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,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

d. More than One Submission Rebuttal Dismissal Model Letter - Stay of Enrollment

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address](Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submissions
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] previously received a rebuttal for [Provider/Supplier Name] on [Month] [DD], [YYYY]. Per Chapter 10.4.9.1(A) of the Medicare Program Integrity Manual, only one rebuttal request may be submitted per stay of enrollment letter. Therefore, [Contractor Name] is unable to accept your additional rebuttal[s] received on [Month] [DD], [YYYY] (list all additional dates if applicable). As a result, [Contractor Name] is dismissing your rebuttal and no decision will be rendered.

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,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[Contractor Name]

e. No Specification of Why the Provider/Supplier Disagrees with Enrollment Stay and Reasons for Disagreement Rebuttal Dismissal Model Letter

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal]

[Address] (Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Dismissal

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

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the Rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], in response to the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

[Contractor Name] is unable to accept your rebuttal as it does not specify the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. The requirement to identify the facts or issues with which you disagree and your reasons for disagreement was stated in the stay of enrollment letter, dated [Month] [DD], [YYYY], in 42 C.F.R. § 424.541(b)(3), and in Chapter 10 of the Medicare Program Integrity Manual. Additionally, in a letter dated [Month] [DD], [YYYY], [Contractor Name] requested that you identify the facts or issues identified in the stay of enrollment letter with which you disagree and your reasons for disagreement. This letter permitted an additional 15 calendar days to submit your response.

(If no response received, use this language: [To date, [Contractor Name] has not received a response. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

(If response received after 15 calendar days, use this language: [While [Contractor Name] received a response, it was not timely received within 15-calendar days. As a result, [Contractor Name] is dismissing your rebuttal, and no decision will be rendered.])

Please note that failure to submit a timely and proper rebuttal submission constitutes a waiver of all rebuttal rights under 42 C.F.R. § 424.541(b)(3).

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,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]
[Contractor Name]

7. Stay of Enrollment Rebuttal Not Actionable (Moot) Model Letter

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Submission
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name], based on the letter dated [Month] [DD], [YYYY] imposing a stay of [Provider/Supplier Name]'s Medicare billing enrollment pursuant to 42 C.F.R. § 424.541.

On [Month] [DD], [YYYY], [Contractor Name] reviewed the stay of enrollment for [Provider/Supplier Name] and [revised imposition letter (OR) lifted the stay]. The [revised imposition letter (OR) rescission letter (OR) letter lifting the stay], dated [Month] [DD], [YYYY], rendered the issue set forth in your rebuttal no longer actionable. For your convenience a copy of the [revised imposition letter (OR) rescission letter (OR) letter lifting the stay] is attached. Accordingly, the issue addressed in your rebuttal is now moot, and we are unable to render a determination on the matter.

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]

[Position of Hearing Officer]
[Contractor Name]

(The contractor shall include PDF copy of the letter that rendered the rebuttal moot (e.g. the revised imposition letter or rescission letter.)

8. Favorable Stay of Enrollment Rebuttal Model Letter

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]
Attn: [Signer/Submitter of Rebuttal]
[Address] (Address from which the Rebuttal was sent)
[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Determination
Legal Business Name: [Provider/Supplier Name] (as it appears in PECOS)
NPI: [XXXXXXXXXXXX]
PTAN: [XXXXXX]
Reference Number: [XXXX] (optional)

Dear [Name of the Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] based on the stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541. (If the rebuttal was timely, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.) [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

APPLICABLE AUTHORITIES: (list any authorities cited in analysis)

- 42 C.F.R. § 424.541
- [enrollment requirement that led to stay]
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable)

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, imposing a stay of Home Healthcare Services, LLC's Medicare enrollment pursuant to § 424.541).

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, as well as a brief description of the document. The contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The stay of enrollment letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether the imposition of the stay and/or the effective date of the stay are correct. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in the “Applicable Authorities” section above. At a minimum, the review shall consist of whether the provider/supplier was non-complaint and whether the non-compliance can be remedy by submitted the applicable CMS form, as well as the effective date of the stay. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] notified Home Healthcare Services, LLC of the [Month] [DD], [YYYY] deadline to revalidate its Medicare enrollment. On [Month] [DD], [YYYY], [Contractor Name] imposed a stay of Home Healthcare Services, LLC’s enrollment. However, [Contractor Name] received a revalidation on [Month] [DD], [YYYY]. Therefore, Home Healthcare Services, LLC was in compliance with the revalidation requirement. As a result, [Contractor Name] finds that the stay of Home Healthcare Services, LLC’s Medicare enrollment was not correct.)

This is a **FAVORABLE DETERMINATION**. To effectuate this determination, [Contractor name] will remove the stay and reinstate [Provider/Supplier Name]’s Medicare enrollment.

(If additional information is needed from the provider/supplier in order to reinstate the enrollment, the Contractor shall state what information is needed from the provider or supplier in this rebuttal determination. Contractors shall state that the requested information/documentation must be received within 30 calendar days of the date of this determination letter)

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

Sincerely,

[Signature of Hearing Officer] (May be electronic)
[Name of Hearing Officer]
[Position of Hearing Officer]

[Contractor Name]

9. Unfavorable Stay of Enrollment Rebuttal Model Letter

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

[Month] [DD], [YYYY]

[Provider/Supplier/Attorney/Firm Name]

Attn: [Signer/Submitter of Rebuttal]

[Address] (Address from which the Rebuttal was sent)

[City], [State] [Zip Code]

Re: Stay of Enrollment Rebuttal Determination

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

NPI: [XXXXXXXXXXXX]

PTAN: [XXXXXX]

Reference Number: [XXXX] (optional)

Dear [Person(s) who submitted the rebuttal]:

This letter is in response to the rebuttal received by [Contractor Name] based on the stay of [Provider/Supplier Name]'s Medicare enrollment pursuant to 42 C.F.R. § 424.541. (If the rebuttal was timely, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]; therefore, this rebuttal is considered timely.] (If the rebuttal is untimely, but good cause has been found to accept the rebuttal, use the following.) [The stay of enrollment letter was dated [Month] [DD], [YYYY] and [Contractor Name] received the rebuttal on [Month] [DD], [YYYY]. This rebuttal was not timely submitted, but a good cause waiver has been granted.] [Contractor Name] based the following determination on the Social Security Act (Act), Medicare regulations, the CMS manual instructions, the Medicare enrollment record, and any information received before this decision was rendered.

APPLICABLE AUTHORITIES: (list any authorities cited in analysis)

- 42 C.F.R. § 424.541
- [enrollment requirement that led to stay]
- Medicare Program Integrity Manual (MPIM) chapter 10.XX (If applicable)

EXHIBITS:

- Exhibit 1: (Example: Rebuttal letter to CMS, signed by Smith, Administrator for Home Healthcare Services, LLC, dated January 1, 2018);
- Exhibit 2: (Example: Letter from [Contractor Name] to Home Healthcare Services, LLC, dated December 1, 2017, imposing a stay of Home Healthcare Services, LLC's Medicare enrollment pursuant to § 424.541).

(In this section list each document submitted by the provider/supplier. Each exhibit shall include the date, as well as a brief description of the document. The Contractor shall also include other documentation not submitted by the provider/supplier that the hearing officer reviewed in making the determination, e.g., enrollment applications, development letters, etc. The stay of enrollment letter shall be included as an Exhibit.)

BACKGROUND:

[Contractor Name] has reviewed the documentation related to the matter for [Provider/Supplier Name] and made the determination in accordance with the applicable Medicare rules, policies, and program instructions.

(Summarize the facts underlying the case which led up to the submission of the rebuttal.)

REBUTTAL ANALYSIS:

(A rebuttal reviews whether the imposition of the stay and/or the effective date of the stay are correct. This section shall summarize the statements made by the provider/supplier in its rebuttal, then provide an analysis of the arguments based on the applicable regulations and sub-regulations, such as the MPIM. Any regulation or sub-regulatory guidance that is referenced in this section shall also be listed in the “Applicable Authorities” section above. At a minimum, the review shall consist of whether the provider/supplier was non-complaint and whether the non-compliance can be remedied by submitted the applicable CMS form, and the effective date of the stay. It is insufficient to state a rebuttal determination without explaining how and why the determination was made.)

DECISION:

(A short conclusory restatement.)

(Example: On [Month] [DD], [YYYY], [Contractor Name] received a revalidation application for Home Healthcare Services, LLC. On [Month] [DD], [YYYY], [Contractor Name] sent a development request to continue processing Home Healthcare Services, LLC’s revalidation application. Home Healthcare Services, LLC did not timely respond to [Contractor Name]’s development request. [Contractor Name] properly rejected Home Healthcare Services, LLC’s revalidation application. As a result, Home Healthcare Services, LLC was non-compliant with the revalidation requirement. Therefore, [Contractor Name] finds that the stay of Home Healthcare Services, LLC’s Medicare enrollment under 42 C.F.R. § 424.541 was appropriately implemented.)

This is an **UNFAVORABLE DETERMINATION**. [Contractor name] concludes that there was no error made in the stay of [Provider/Supplier Name]’s Medicare enrollment. As a result, **the stay of [Provider/Supplier Name]’s enrollment remains intact**. During this stay, claims for services and items [Provider/Supplier Name] furnishes during this period will be rejected. However, this does not affect [Provider/Supplier Name]’s Medicare participation agreement or any of its conditions, and [Provider/Supplier Name] remains enrolled in the Medicare program.

NEXT STEPS:

Failure to (choose applicable requirement that led to stay of enrollment) [timely revalidate your Medicare enrollment (OR) timely submit a Change of Information application] may result in a deactivation or revocation of your Medicare enrollment. If you are a non-certified provider/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.

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,

[Signature of Hearing Officer] (May be electronic)

[Name of Hearing Officer]

[Position of Hearing Officer]

[Contractor Name]

***10.7.21 – DMEPOS Supplier Change in Majority Ownership Letter
(Rev. 13717; Issued: 07-08-26; Effective: 01-01-26; Implementation: 08-07-26)***

[Month, Day, Year]

[DMEPOS Supplier Name]

[Address]

[City] ST [Zip]

Reference # (Application Tracking Number)

Dear [DMEPOS Supplier Seller],

[Insert Contractor name] has [Insert appropriate situation (e.g., reviewed [DMEPOS supplier's current name] change of ownership application and learned that [DMEPOS supplier's current name] may have undergone a change in majority ownership pursuant to 42 Code of Federal Regulations (CFR) § 424.551; etc.]. After our review, [Insert Contractor name] has determined that [DMEPOS supplier's current name] has undergone a change in majority ownership under 42 C.F.R. § 424.551 and that none of the exceptions described in 42 C.F.R. § 424.551(c) apply to this situation. Pursuant to 42 C.F.R. § 424.551, therefore, [insert DMEPOS supplier's current name] and Medicare billing privileges do not convey to the new owner. The prospective supplier/owner of [insert DMEPOS suppliers' current name] must instead:

- Enroll in the Medicare program as a new (initial) DMEPOS supplier under the provisions of 42 C.F.R § 424.510; and*
- Undergo a survey by, and obtain a new accreditation from, a CMS-approved DMEPOS accreditation organization in accordance with § 424.57 and § 424.58.*

Consistent with the foregoing, [insert DMEPOS supplier's current name] enrollment [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)].

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 supplier, the authorized or delegated official, or a legal representative.

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

If the supplier has an attorney sign the rebuttal, the rebuttal must include a statement from the attorney that the attorney has the authority to represent the 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:

*Chags Health Information Technology LLC
P.O. Box 45266
Jacksonville, FL 32232
Phone: (800) 245-9206
E-mail: PEARC@c-hit.com*

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]