CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 474	**Date: July 5, 2013**
	Change Request 8341

SUBJECT: Update to Chapter 15 of the Program Integrity Manual (PIM)

I. SUMMARY OF CHANGES: The purposes of this CR are to: (1) incorporate certain provider enrollment policy and operational clarifications into chapter 15 of the PIM, and (2) restore certain sections to chapter 15 that were previously and inadvertently deleted.

EFFECTIVE DATE: October 8, 2013
IMPLEMENTATION DATE: October 8, 2013

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	15/15/4.1.9/Indian Health Services (IHS) Facilities
R	15/15/4.4.9/Occupational and Physical Therapists in Private Practice
R	15/15/5.2.2/Correspondence Address and E-mail Addresses
R	15/15/5.5/Owning and Managing Organizations
R	15/15/6.1/Standards for Initial Applications
R	15/15/7.5/Special Program Integrity Procedures
R	15/15/7.7.2/Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15/7.8.2/Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) - Initial Enrollment
R	15/15/7.8.3.1/Examining Whether a CHOW May Have Occurred
R	15/15/7.8.4/Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15/8.1/Returns
R	15/15/8.2/Rejections
R	15/15/8.4/Denials
R	15/15/11/Electronic Fund Transfers (EFT)
N	15/15/16.5/Conversion from Form CMS-855O to Form CMS-855I – PECOS Requirements
R	15/15/19.1/Application Fees
R	15/15/19.2.4/Reactivations
R	15/15/25.1.2/Reconsideration Requests - Non-Certified Providers/Suppliers
R	15/15/25.2.2/Reconsideration Requests - Certified Providers and Certified Suppliers
R	15/15/27.1/Deactivations and Reactivations
N	15/15/27.1.1/Deactivations
N	15/15/27.1.2/Reactivations
N	15/15/27.1.2.1/Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim
N	15/15/27.1.2.2/Reactivations - Deactivation for Non-Submission of a Claim
N	15/15/27.1.2.3/Reactivations – Miscellaneous Policies
R	15/15/27.2/Revocations

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged 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

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 474	Date: July 05, 2013	Change Request: 8341

SUBJECT: Update to Chapter 15 of the Program Integrity Manual (PIM)

EFFECTIVE DATE: October 8, 2013
IMPLEMENTATION DATE: October 8, 2013

I. GENERAL INFORMATION

A. Background: The purposes of this CR are to: (1) incorporate certain provider enrollment policy and operated clarifications into chapter 15 of the PIM, and (2) restore certain sections to chapter 15 that were inadvertently deleted in a prior CR.

B. Policy: This CR is designed to: (1) incorporate certain provider enrollment policy and operated clarifications into chapter 15 of the PIM, and (2) restore certain sections to chapter 15 that were inadvertently deleted in a prior CR.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8341.1	If an Indian Health Services (IHS) facility or tribal provider mails its Form CMS-855 to a Medicare contractor other than Novitas Solutions, Inc., the contractor shall forward the application directly to Novitas at the address listed in section 15.4.1.9(B) of chapter 15.	X	X			X	X	X					
8341.2	Excluding the circumstances described in sections 15.7.5(A) through (E) of chapter 15, if the contractor determines in a particular case that a driver's license or passport is necessary to confirm the identity of the provider, supplier, or signatory, it shall obtain approval from its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) before requesting the license/passport.	X	X			X	X	X					
8341.3	If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its PEOG BFL notifying him or her of the return.	X	X			X	X	X					
8341.4	If the contractor returns a change of information or CHOW submission and the applicable 90-day or	X	X			X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	30-day period for reporting the change has not expired, the contractor shall send the e-mail referred to in business requirement 8341.3 after the expiration of said time period unless the provider has resubmitted the change request/CHOW.												
8341.4.1	If the provider resubmits the change of information or CHOW application and the contractor returns it again, rejects it, or denies it, the contractor shall send the e-mail referred to in business requirement 8341.3 regardless of whether the applicable timeframe has expired.	X	X			X	X	X					
8341.5	If the contractor returns a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.	X	X			X	X	X					
8341.6	If the contractor returns a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application.	X	X			X	X	X					
8341.6.1	If the provider resubmits the revalidation application and the contractor returns it again, rejects it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.	X	X			X	X	X					
8341.7	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 expired, the contractor shall send an e-mail to its PEOG BFL notifying him or her of the rejection.	X	X			X	X	X					
8341.8	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 expired, the contractor shall send the e-mail	X	X			X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	referred to in business requirement 8341.7 after the expiration of said time period unless the provider has resubmitted the change request/CHOW.												
8341.8.1	If the provider resubmits the change of information or CHOW application and the contractor rejects it again, returns it, or denies it, the contractor shall send the e-mail referred to in business requirement 8341.7 regardless of whether the applicable timeframe has expired.	X	X			X	X	X					
8341.9	If the contractor rejects a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.	X	X			X	X	X					
8341.10	If the contractor rejects a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application.	X	X			X	X	X					
8341.10.1	If the provider resubmits the revalidation application and the contractor rejects it again, returns it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.	X	X			X	X	X					
8341.11	Absent a CMS instruction or directive to the contrary, the contractor shall send a denial letter to the provider or supplier (1) no later than 5 business days after the contractor concludes that the provider or supplier's application should be denied, or (2) if the denial requires prior PEOG authorization, no later than 5 business days after PEOG notifies the contractor of such authorization.	X	X			X	X	X					
8341.12	If the contractor denies a change of information or CHOW submission and the applicable 90-day or	X	X			X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	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 denial.												
8341.13	If the contractor denies a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not expired, the contractor shall send the e-mail referred to in business requirement 8341.12 after the expiration of said time period unless the provider has resubmitted the change request/CHOW.	X	X			X	X	X					
8341.13.1	If the provider resubmits the change of information or CHOW application and the contractor denies it again, returns it, or rejects it, the contractor shall send the e-mail referred to in business requirement 8341.12 regardless of whether the applicable timeframe has expired.	X	X			X	X	X					
8341.14	If the contractor denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.	X	X			X	X	X					
8341.15	If the contractor denies a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application.	X	X			X	X	X					
8341.15.1	If the provider resubmits the revalidation application and the contractor denies it again, returns it, or rejects it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.	X	X			X	X	X					
8341.16	In cases where an individual provider seeks to convert his or her current Form CMS-855O application to a Form CMS-855I enrollment or		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	vice versa, the contractor shall (1) review the enrollments to be withdrawn in the ADR in PECOS Administrative Interface (AI) (2) review this information and take the appropriate action to voluntarily withdraw the enrollments listed, (3) begin working the Form CMS-855I enrollment but leave it in “In Review” status while withdrawing the other enrollments, (4) use a logging and tracking (L&T) submittal reason of "Voluntary Termination" to withdraw the Form CMS-855O enrollment, and (5) use an effective date for the withdrawn enrollments of one day prior to the effective date of the Form CMS-855I enrollment.												
8341.16.1	If it is determined that the Form CMS-855O enrollment requiring withdrawal is outside of the contractor’s jurisdiction, the contractor shall notify the other contractor via email using the “Associate Profile Contact List” and state that the enrollment needs to be voluntary withdrawn; the second contractor shall take action based on the email and include the email in its files as documentation.		X				X						
8341.16.2	If the provider submits a paper Form CMS-855I application and it is determined that a current Form CMS-855O enrollment exists within the contractor's jurisdiction, the contractor shall voluntarily withdraw the Form CMS-855O enrollment.		X				X						
8341.16.3	If the provider submits a paper Form CMS-855O to voluntarily withdraw his or her enrollment as well as a paper Form CMS-855I to begin billing Medicare, the contractor shall not contact the provider to confirm the submissions unless the contractor has reason to believe that what was submitted was not the provider’s intention.		X				X						
8341.16.4	If it is determined that the provider submitted applications to convert his or her existing Form CMS-855O enrollment into a Form CMS-855I enrollment in error (either via paper or Internet-based PECOS), the contractor shall reject the application, thus returning the enrollment record back to its previous state.		X				X						
8341.17	In the "year-to-year" fee payment cases described	X	X			X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	in section 15.19.1(E) of chapter 15, the contractor shall (1) send an e-mail to its PEOG BFL requesting a full refund of the fee and including any pertinent documentation in support of the request, and (2) send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the correct fee amount (i.e., the Year 2 amount) via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations); the letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.												
8341.17.1	During this 30-day period, the contractor shall determine whether the correct fee has been paid via Pay.gov; if it is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR §424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).	X	X			X	X	X					
8341.17.2	If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof that the correct fee amount (i.e., the Year 2 amount) has been paid, the contractor shall begin processing the application as normal.	X	X			X	X	X					
8341.18	If the contractor encounters one of the three deactivation situations described in section 15.27.1.1(A) of chapter 15, the contractor shall contact its PEOG BFL (via any means) and request approval of the deactivation.	X	X			X	X	X					
8341.19	Upon receipt of a reactivation certification package (RCP), the contractor shall (1) ensure that it is complete and contains all required elements, (2) review all names listed in the provider's enrollment record against the Medicare Exclusion Database or the General Services Administration Access Management System, (3) ensure that the provider is still appropriately licensed and/or certified, (4) perform a site visit if the provider is	X	X			X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	in the moderate or high screening category, (5) if applicable under section 15.27.1.2.2(B)(2), process the changed information in accordance with the instructions in chapter 15, and (6) develop for missing/incomplete information if the RCP is deficient.												
8341.19.1	If the contractor determines that any of these criteria are not met, it shall deny the RCP in accordance with existing instructions for reactivation denials unless it determines that rejection is more appropriate because the provider did not adequately respond to the contractor's developmental request.	X	X			X	X	X					
8341.20	Absent a CMS instruction or directive to the contrary, the contractor shall send a revocation letter to the provider or supplier: (1) no later than 5 business days after the contractor concludes that the provider or supplier's billing privileges should be revoked, or (2) If the revocation requires prior PEOG authorization, no later than 5 business days after PEOG notifies the contractor of such authorization.	X	X			X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8341.21	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one	X	X			X	X	X	

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.474, Issued: 07-05-13)

15.4.1.9 - Indian Health Services (IHS) Facilities

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. General Background Information

For purposes of provider enrollment only, there are several types of IHS facilities: (1) those that are wholly owned and operated by the IHS, (2) facilities owned by the IHS but tribally operated, and (3) facilities wholly owned and operated by a tribe, though under the general IHS umbrella. When an IHS facility wishes to enroll with the Part A contractor, it may check either: (a) "Indian Health Services Facility," or (b) the specific provider type it is. For instance, if an IHS hospital is involved, the provider may check "Indian Health Services Facility" or "Hospital" on the application - or perhaps both. Even if it only checked "Hospital," the LBN or DBA Name will typically contain some type of reference to Indian Health Services. The contractor will therefore know that it is dealing with an IHS facility.

The overwhelming majority of IHS facilities on the Part A side are either hospitals, skilled nursing facilities (SNFs), critical access hospitals, or end-stage renal disease facilities. The contractor processes IHS applications in the same manner (and via the same procedures) as it would with a hospital, SNF, etc. (This also applies to procedures for PECOS entry.)

As for CCN numbers, the IHS facility uses the same series that its concomitant provider type does. That is, an IHS hospital uses the same CCN series as a "regular" hospital, an IHS CAH utilizes the same series as a regular CAH, and so forth.

B. IHS Enrollment

*I*HS facilities and tribal providers may use Internet-based PECOS or the paper *F*orm CMS-855 enrollment application *for their enrollment transactions. The designated Medicare contractor for IHS facilities and tribal providers is Novitas Solutions (Novitas)*.

If the IHS facility or tribal provider *mails its Form CMS-855* to a Medicare contractor other than *Novitas*, that contractor shall forward the *application* directly to *Novitas at the* following address*:*

Novitas Solutions, Inc.
P.O. Box 890115
Camp Hill, PA 17089-0115

*I*n Section 2 of the Form CMS-855A and Form CMS-855B applications, the provider or supplier must identify whether it is an Indian Health Facility enrolling with *Novitas.*

C. Licensure Requirements for Physicians and Practitioners Enrolling to Work in or Reassign Benefits to an Indian Tribe or Tribal Organization

The Affordable Care Act (Pub. L 111-148) amended Section 221 of the Indian Health Care Improvement Act (IHCIA) to provide as follows:

> Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State, in which the tribal program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450, et seq.).

Pursuant to this statutory provision, any physician or practitioner need only be licensed in one State – regardless of whether that State is the one in which the practitioner practices – if he or she is employed by a tribal health

program performing services as permitted under the ISDEAA (see CMS Pub. 100-04, chapter 19, section 10 for definitions).

The contractor shall apply this policy when processing applications from these individuals. In terms of the effective date of Medicare billing privileges, the contractor shall continue to apply the provisions of 42 CFR §424.520(d) and section 15.17 of this chapter.

For additional general information on IHS facilities, see Pub. 100-04, chapter 19.

15.4.4.9 - Occupational and Physical Therapists in Private Practice

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Occupational Therapists

As stated in Pub. 100-02, chapter 15, section 230.2(B), a qualified occupational therapist for program coverage purposes is an individual who meets one of the following requirements:

- Is a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education of the American Medical Association and the American Occupational Therapy Association;

- Is eligible for the National Registration Examination of the American Occupational Therapy Association; or

- Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist after December 31, 1977.

B. Physical Therapists

As stated in Pub. 100-02, chapter 15, section 230.1(B), a qualified physical therapist for program coverage purposes is a person who is licensed as a physical therapist by the State in which he or she is practicing and meets one of the following requirements:

- Has graduated from a physical therapy curriculum approved by (1) the American Physical Therapy Association, (2) the Committee on Allied Health Education and Accreditation of the American Medical Association, or (3) Council on Medical Education of the American Medical Association, and the American Physical Therapy Association; or

- Prior to January 1, 1966, (1) was admitted to membership by the American Physical Therapy Association, (2) was admitted to registration by the American Registry of Physical Therapists, or (3) has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

- Has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or

- Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or

- If trained outside the United States, (1) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, and (2) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

C. Site Visits of Physical Therapists

Subject to subsection D below, site visits will be performed in accordance with the following:

- Initial application – If a physical therapist (PT) or PT group submits an initial application, the contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS). This is to ensure that the supplier is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the supplier prior to the completion of the NSVC's site visit and the contractor's review of the results.

- Revalidation – If a PT or PT group submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the supplier is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

- New/changed location – Unless CMS has directed otherwise, if a PT or PT group is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS. This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the application prior to the completion of the NSVC's site visit and the contractor's review of the results.

D. Additional Site Visit Information

NOTE: The contractor shall also view the following:

- In section 2A of the Form CMS-855B application, physical and occupational therapy groups are denoted as "Physical/Occupational Therapy Group(s) in Private Practice." If a supplier that checks this box in section 2A is exclusively an occupational therapy group in private practice – that is, there are no physical therapists in the group – the contractor shall process the application using the procedures in the "limited" screening category. No site visit is necessary. If there is at least one physical therapist in the group, the application shall be processed using the procedures in the "moderate" screening category. A site visit by the NSVC is required, unless CMS has directed otherwise.

- If an entity is enrolled as a physician practice and employs a physical therapist (PT) within the practice, the practice itself falls within the "limited" screening category. This is because the entity is enrolled as a physician practice, not a physical therapy group in private practice.

- If a newly-enrolling physical therapist lists several practice locations, the enrollment contractor has the discretion to determine the location at which the NSVC will perform the required site visit.

- Unless CMS has directed otherwise, a site visit by the NSVC is required when a physical therapist submits an application for initial enrollment and reassignment of benefits (Form CMS-855I and Form CMS-855R). However, a site visit is not required for an enrolled physical therapist who is reassigning his or her benefits only (Form CMS-855R).

- If the physical therapist's practice location is his or her home address and it exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

E. Continued Moderate Risk

A PT shall remain in the "moderate" screening category (and shall be denoted as such in the Provider Enrollment, Chain and Ownership System (PECOS)) even if:

- *No site visit is ultimately performed, or*
- *The PT works for and/or reassigns his or her benefits to an entity (such as a physician group practice) that is in the "limited" screening category.*

To illustrate, and as explained above, if an entity is enrolled as a physician practice and employs a physical therapist (PT) within the practice, the practice itself falls within the "limited" screening category; this is because the entity is enrolled as a physician practice, not a physical therapy group in private practice. However, while the physician group is in the "limited" screening category, the PT remains in the "moderate" screening category per § 424.518(b)(1)(vii).

In short, a PT shall always be treated as being in the "moderate" screening category. The fact that a site visit may not have been performed (due to, for instance, logistical issues) or that the PT is employed by a supplier in the "limited" screening category does not change this.

For more information on physical and occupational therapists, refer to:

- 42 CFR § 410.59(c) (occupational therapists)
- 42 CFR § 410.60(c) (physical therapists)
- Pub. 100-02, chapter 15, sections 230.2 and 230.4 (Benefit Policy Manual) (occupational therapists)
- Pub. 100-02, chapter 15, sections 230.1 and 230.4 (Benefit Policy Manual) (physical therapists)

15.5.2.2 – Correspondence Address and E-mail Addresses

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Correspondence Address - Background

The correspondence address must be one where the contractor can directly contact the applicant to resolve any issues once the provider is enrolled in the Medicare program. It cannot be the address of a billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). It can, however, be a P.O. Box or, in the case of an individual practitioner, the person's home address.

The contractor shall call the telephone number listed in this section to verify that the contractor can get in touch with the applicant. If an answering service appears and the contractor can identify it as the applicant's personal service, it is not necessary to talk directly to the applicant or an official thereof. The contractor only needs to verify that the applicant can be reached at this number.

B. Contact Person

The contractor should use the contact person listed in section 13 of the Form CMS-855 for all communications directly related to the provider's submission of an initial enrollment application, change of information request, etc. All other provider enrollment-oriented matters shall be directed to the correspondence address. For instance, assume a provider submits an initial Form CMS-855 on March 1. The application is approved on April 15. All communications specifically related to the Form CMS-855

submission between March 1 and April 15 should be sent to the contact person (or, if section 13 is blank, to an authorized/delegated official or the individual practitioner). After April 15, all provider enrollment-oriented correspondence shall go to the correspondence address. Assume further that the provider submits a change of information request on August 1, which the contractor approves on August 30. All communications directly related to the change request should go to the designated contact person between August 1 and August 30.

Notwithstanding the above, all approval (or recommendation for approval) and denial letters should be sent to the contact person. However, the contractor retains the discretion to send the letter to another address listed on the Form CMS-855 if circumstances dictate.

The contractor has the discretion to determine whether a particular communication is "specifically related" to a Form CMS-855 submission or whether a particular communication is "provider enrollment-oriented."

C. E-mail Addresses

An e-mail address listed on the application can be a generic e-mail address. It need not be that of a specific individual. The contractor may accept a particular e-mail address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider.

15.5.5 – Owning and Managing Organizations

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

(This section only applies to section 5 of the Form CMS-855A and Form CMS-855B. It does not apply to the Form CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the Form CMS-855:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

The following illustrates the difference between direct and indirect ownership:

EXAMPLE: The supplier listed in section 2 of the Form CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. Company A is considered to be a direct owner of the supplier (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the supplier. In other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.

See the instructions for section 5 of the Form CMS-855 for additional information on indirect ownership.

2. Mortgage or security interest

For purposes of enrollment, ownership also includes "financial control." Financial control exists when:

(a) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, and

(b) The interest is equal to or exceeds 5 percent of the total property and assets of the provider.

All entities with at least a 5 percent mortgage, deed of trust or other security interest in the provider must be reported in section 5. This frequently will include banks, other financial institutions, and investment firms,

3. Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

4. For limited partnerships, any limited partnership interest that is 10 percent or greater.

5. Managing control of the provider or supplier

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, the entity could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

The organizations referred to above generally fall into one or more of the following categories:

- Corporations
- Partnerships and limited partnerships
- Limited liability companies
- Charitable and religious organizations
- Governmental/tribal organizations
- Banks and financial institutions
- Investment firms
- Holding companies
- Trusts and trustees
- Medical providers/suppliers
- Consulting firms
- Management services companies
- Medical staffing companies
- Non-profit entities

In section 5(A)(2) of the Form CMS-855, the provider must indicate the type(s) of organizational categories the reported entity falls into.

The following principles also apply with respect to section 5:

a. Diagrams – In addition to completing section 5(A):

- The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other. (This applies to the Form CMS-855A, CMS-855B and CMS-855S.)

- If the provider is a skilled nursing facility (SNF), it must submit a diagram/flowchart identifying the organizational structures of all of its owners, including those that were not required to be listed in section 5 or 6. This must be submitted in addition to the diagram/flowchart in the previous bullet.

These diagrams/flowcharts must be submitted for initial enrollments, revalidations, *Form CMS-855 reactivations,* and upon any contractor reques*t.*

b. Percentage of Interest (section 5(B)) – The provider need not:

- Disclose a percentage of managerial control

- Submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.

c. Section 2 - Any entity listed as the provider in section 2 of the Form CMS-855 need not be reported in section 5A. The only exception involves governmental entities, which must be identified in section 5A even if they are already listed in section 2.

d. Governmental and Tribal Organization Letter - For governmental and tribal organizations, the letter referred to in the Form CMS-855 instructions for section 5 must be signed by an appointed or elected official of the governmental or tribal entity who has the authority to legally and financially bind the governmental or tribal entity to the laws, regulations, and program instructions of Medicare. This governmental or tribal official is not required to be an authorized official, or vice versa.

e. Non-Profit Organizations - Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body must be listed in section 5A of the Form CMS-855. The provider must submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the provider may submit any other documentation that supports its claim (e.g., written documentation from the State).

Governmental and tribal entities need not submit a copy of a 501(c)(3) if it is otherwise obvious to the contractor that the entity is a governmental or tribal entity. The contractor can assume that the governmental or tribal entity is non-profit.

f. IRS CP-575 - Owning/managing organizations need not furnish an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a potential discrepancy between the organization's reported legal business name and tax identification number.

g. Documentation – Proof of ownership, managerial control, security interest, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.

h. Partnerships – Only partnership interests in the enrolling provider need be disclosed in section 5. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 5.

15.6.1 – Standards for Initial Applications

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

For purposes of sections 15.6.1.1 through 15.6.1.4 of this chapter, the term "initial applications" also includes:

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

2. "Complete" Form CMS-855 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), (c) as a *Form CMS-855* reactivation, or (d) as a revalidation.

3. Reactivation certification packages (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter).

15.7.5 – Special Program Integrity Procedures

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

This section contains additional verification procedures that the contractor shall utilize when processing the following transactions:

- Changes in the provider's practice location
- Changes in the provider's correspondence or special payment address
- On the Form CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number
- *Revalidations* and *Form CMS-855 Reactivations*

The instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter and in other CMS directives. Also, unless otherwise stated, section 15.7.5 applies to the Form CMS-855A, Form CMS-855B and Form CMS-855I.

The signature comparison requirements stated below are not necessary if the Form CMS-855 or Form CMS-588 change request, reactivation, or revalidation was submitted with an electronic signature.

A. Change in Practice Location Address

In cases where a provider submits a Form CMS-855 request to change its practice location address, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For Form CMS-855A and Form CMS-855B submissions that were not signed electronically, if the person's signature is not already on file the contractor shall request that he/she (1) complete section 6 of the Form CMS-855 and (2) furnish his/her signature in section 15 or 16 of the Form CMS-855.

2. Contact the location currently associated with the provider in the Provider Enrollment, Chain and Ownership System (PECOS) or the Multi-Carrier System (MCS) to verify that the provider is no longer there and did in fact move.

3. Request that the provider fax to the *contractor a* copy of a phone bill/power bill *or other documentation* containing the business's new legal business name (LBN) or doing business as (DBA) name and its new address.

B. Change in Correspondence or Special Payments Address

If the provider submits a change to its correspondence or special payments address, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's

license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For Form CMS-855A and Form CMS-855B submissions that were not signed electronically, if the person's signature is not already on file the contractor shall request that he/she (1) complete section 6 of the Form CMS-855 and (2) furnish his/her signature in section 15 or 16 of the Form CMS-855.

2. Contact the individual physician/practitioner (for Form CMS-855I changes), an authorized or delegated official (for Form CMS-855A and Form CMS-855B changes), or the contact person listed in section 13 (for Form CMS-855A, Form CMS-855B, and Form CMS-855I changes) to verify the change. Hence, 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.

C. Change of EFT Information

If the provider submits a Form CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For organizational providers whose submissions were not signed electronically, if the person's signature is not already on file the contractor shall request that he/she (1) complete section 6 of the CMS-855 and (2) furnish his/her signature in section 15 or 16 of the Form CMS-855.

2. Contact the individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A and Form CMS-855B enrollees), or the section 13 contact person on record (for Form CMS-855A, Form CMS-855B, and Form CMS-855I enrollees) to verify the change. Hence, 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.

D. *Revalidations and Form CMS-855 Reactivations*

When processing a *revalidation or Form CMS-855 reactivation* application, the contractor shall – unless *another CMS directive instructs otherwise* - undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For Form CMS-855A and Form CMS-855B applications that were not signed electronically, if the person's signature is not already on file the contractor shall request that he/she (1) complete section 6 of the Form CMS-855 and (2) furnish his/her signature in section 15 or 16 of the Form CMS-855.

2. If the (a) practice location address or (b) correspondence/special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS, the contractor shall abide by the instructions in subsections A and B above, respectively.

E. Reassignment of All Benefits

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, professional association, or limited liability company, the contractor shall:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

2. Call the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner and request that he/she fax to the contractor a copy of his/her driver's license.

F. Driver's License and Passport Requests

Excluding the circumstances described in (A) through (E) above, if the contractor determines in a particular case that a driver's license or passport is necessary to confirm the identity of the provider, supplier, or signatory, it shall obtain approval from its Provider Enrollment Operations Group Business Function Lead before requesting the license/passport. As a reminder, moreover, the license/passport shall only be requested in situations (A) through (E) if the signatures do not match.

G. **Potential Identity Theft or Other Fraudulent Activity**

In conducting the verification activities described in this section 15.7.5, if the contractor believes that a case of identity theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), the contractor shall notify its Provider Enrollment Operations Group Business Function Lead immediately.

15.7.7.2 - Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice (CMS-2007) is generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

4. Involuntary terminations (e.g., provider no longer meets conditions of participation or coverage) prompted by the State/RO

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the State/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855 Changes of Information

1. Referrals to State/RO

The following is a list of Form CMS-855A changes of information that require a recommendation and referral to the State/RO:

- Addition of outpatient physician therapy/outpatient speech pathology extension site
- Addition of hospice satellite
- Addition of home health agency branch
- Change in type of Prospective Payment System (PPS)-exempt unit
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Change in practice location or subunit address in cases where a survey of the new site is required
- Stock transfer

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the change/addition.

2. Post-Approval RO Contact Required

Form CMS-855A changes that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or hospital subunits
- Legal business name, tax identification number, or "doing business as name" changes that do not involve a CHOW
- Address changes that do not require a survey of the new location
- Addition of hospital practice location

For these transactions, the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO shall specify the type of information that is changing.

3. All Other Changes of Information

For all Form CMS-855A change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the provider via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

4. Revalidations, *Form CMS-855A* Reactivations and Complete Form CMS-855*A* Applications

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

If the application contains new/changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to "approved." It shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

C. Provider-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice or approval letter from the RO for a transaction/change regarding information that is not collected on the Form CMS-855A, the contractor need not ask the provider to submit a Form CMS-855A change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the provider's Medicare participation because the provider no longer meets the conditions of participation, the contractor need not send a letter to the provider notifying it that its Medicare participation/enrollment has been terminated. (The RO will issue such a letter and afford appeal rights.)

E. Other Procedures Related to Tie-In Notices, Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855A Not Completed - If the contractor receives a tie-in notice or approval letter from the RO but the provider never completed the necessary Form CMS-855A, the contractor shall have the provider complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency – There may be instances when the RO delegates the task of issuing tie-in notices, tie-out notices or approval letters to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, HHA branch additions) for which this function has been delegated.

3. Review for Consistency - When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855A. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

4. Creation of New Logging and Tracking (L & T) Record Unnecessary - The contractor is not required to create a new L & T record in PECOS when the tie-in notice arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Provider Inquiries – Once the contractor has made its recommendation for approval to the State/RO, any inquiry the contractor receives from the provider regarding the status of its request for Medicare participation shall be referred to the State or RO.

6. Timeframes - So as not to keep the PECOS record in "*Approval Pending Regional Office Review*" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

15.7.8.2 - Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) - Initial Enrollment

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

Unlike other supplier types that enroll via the Form CMS-855B, ASCs and PXRSs must receive a State survey and RO approval before they can enroll in Medicare. Accordingly, once it finishes reviewing the supplier's application, the contractor may only make a recommendation for approval to the State. The contractor shall not enroll the supplier until it receives a tie-in notice or approval letter from the RO and – in the case of PXRSs - a follow-up site visit is performed per section 15.4.2.5 of this chapter.

When enrolling the ASC or PXRS, the contractor shall use the effective date that is indicated on the tie-in notice/approval letter. This is the date from which the supplier can bill for services. *See section 15.7.8.4 of this chapter for more information on ASC/PXRS tie-in notices/approval letters.*

15.7.8.3.1 – *Examining Whether a CHOW May Have Occurred*

(Rev.474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)

A. Review of Sales Agreement

If the "Change of Ownership" box in section 1B of the Form CMS-855B is checked, the contractor shall ensure that the entire application is completed and that the supplier submits a copy of the sales agreement. The contractor shall review the sales agreement to determine whether:

1. The ownership change qualifies as a CHOW under the principles of 42 CFR §489.18 and Pub. 100-07, chapter 3, section 3210.1D;

2. Its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner;

3. The information contained in the agreement is consistent with that reported on the new owner's Form CMS-855B (e.g., same names)

If the sales agreement is unclear as to issues 1 and 2 above, the contractor shall request clarifying information from the supplier. (NOTE: Some sales agreements may fail to specifically refer to Medicare supplier agreements, assets, and/or liabilities, therefore requiring a close review of the sales agreement in its totality.) The information shall be in the form of additional legal documentation or a letter. If the clarification – for whatever reason - requires an update to the supplier's Form CMS-855B application, the contractor shall request the submission of said update. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the Form CMS-855B (issue 3 above), the contractor shall seek clarifying information and, if necessary, obtain an updated Form CMS-855B.

In reviewing the application and the sales agreement, the contractor shall keep in mind the following:

- *There may be instances where the parties in a CHOW did not sign a "sales agreement" in the conventional sense of the term; the parties, for example, may have documented their agreement in a "bill of sale." The contractor may accept this alternative documentation in lieu of a sales agreement so long as the document furnishes clear verification of the terms of the transaction.*

- *While a CHOW is usually accompanied by a TIN change, this is not always the case; there may be a few instances where the TIN remains the same. Conversely, there may be cases where a supplier is*

changing its TIN but not its ownership. So while a change of TIN (or lack thereof) is evidence that a CHOW has or has not occurred, it is not the most important factor; rather, the change in the provider's ownership structure is.

- *Form CMS-855B CHOW applications may be accepted by the contractor up to 90 calendar days prior to the anticipated date of the proposed ownership change. Any application received more than 3 months in advance of the projected sale date shall be returned under section 15.8.1 of this chapter.*

- *On occasion, an ASC or PXRS may submit a Form CMS-855B change of information to report a large-scale stock transfer or other significant ownership change that the supplier does not believe qualifies as a CHOW. If the contractor has any reason to suspect that the transaction in question may indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).*

If – after performing the necessary research – the contractor remains unsure as to whether a CHOW has occurred and/or whether the new owner is accepting assignment, the contractor may refer the matter to the RO for guidance. Such referrals to the RO should only be made if the contractor is truly uncertain as to whether a CHOW and/or acceptance of assignment has taken place and should not be made as a matter of course. A RO CHOW determination is usually not required prior to the contractor making its recommendation.

B. Processing Steps

After performing the steps identified in subsection (A) above, the contractor shall abide by the following:

1. If the contractor believes that a CHOW has occurred but the new owner is not accepting the assets and liabilities of the old owner, the contractor shall treat the ASC/PXRS as a brand new supplier. It shall notify the ASC/PXRS that it must submit: (1) a Form CMS-855B voluntary termination to terminate the "old" facility, and (2) a Form CMS-855B initial enrollment for the "new" facility.

2. If the contractor believes that a CHOW has taken place and that the new owner is accepting the old owner's assets and liabilities, it shall process the application normally and make a recommendation for approval to the State (with a cc: to the RO) or, if applicable, issue a denial. If the valid CHOW/acceptance of assignment was accompanied by a change in TIN, the transaction must be treated as a CHOW notwithstanding the general rule that a TIN change constitutes an initial enrollment. In other words, the reporting rules regarding CHOWs/assignments in this particular situation take precedence over the "change of TIN" principle.

3. If the contractor believes that a CHOW has not occurred and that the transaction merely represents an ownership change (e.g., minor stock transfer) that does not qualify as a 42 CFR §489.18-type CHOW, the transaction must be reported as a change of information. The only exception to this is if the change of information was accompanied by a change of TIN, in which case the supplier must enroll as a new entity.

NOTE: It is not uncommon for a supplier to undergo a financial or administrative change that it considers to be a CHOW but in actuality does not meet the regulatory definition identified in §489.18.

In scenario 2 above, the contractor shall not forward a copy of the CHOW application to the State agency until it has received and reviewed the <u>final</u> sales agreement. (In some cases, the supplier may submit an interim sales agreement with its application; this is acceptable, so long as it submits the final agreement in accordance with these instructions.) If the final sales agreement is not submitted within 90 days after the contractor's receipt of the new owner's application, the contractor shall reject the application. Though the contractor must wait until the 90th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what type of responses (short of the actual receipt of the sales agreement) were obtained.

C. Entry into the Provider Enrollment, Chain and Ownership System (PECOS)

If it appears that the new owner will be accepting assignment as well as the assets and liabilities of the old owner, the contractor shall enter the changed data into the old owner's enrollment record in PECOS and, if applicable, switch the record to an "Approval Pending Regional Office Review" status. A new enrollment record shall not be created. If the RO approves the CHOW and sends the tie-in/approval notice to the contractor, the supplier's CMS Certification Number (CCN) will be maintained and the information in the existing record will be updated to reflect the new owner's information once the record is switched to an approved status.

If it appears that the new owner will not be accepting assignment as well as the assets and liabilities of the old owner, a new enrollment record shall be created containing the new owner's information.

D. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the supplier shall - per Pub. 100-7, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

15.7.8.4 - Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO

(Rev.474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)

(For purposes of this section 15.7.8.4, the terms "tie-in notices" and approval letters will be collectively referred to as tie-in notices. "Tie-out notices" are notices from the RO to the contractor that, in effect, state that the ASC's/PXRS's participation in Medicare should be terminated.)

A. Issuance of Tie-In/Tie-Out Notices

A tie-in or tie-out notice is generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

4. Involuntary terminations (e.g., supplier no longer meets conditions of coverage) prompted by the State/RO.

With the exception of voluntary and involuntary terminations, each of the transactions described above requires a referral and recommendation to the State/RO.

(Depending on the specific RO, certain changes of information may also result in the issuance of a CMS-2007.)

B. Form CMS-855B Changes of Information

1. Referrals to State/RO

The following is a list of transactions that require a recommendation and referral to the State/RO:

- Addition of practice location
- Stock transfer
- Change in practice location or address in cases where a survey of the new site is required

In these situations, the Provider Enrollment, Chain and Ownership System (PECOS) record should not be switched to "approved" until the contractor receives notice from the RO that the latter has authorized the change/addition.

2. Post-Approval RO Contact Required

Changes that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- Deletions/voluntary terminations of practice locations or subunits
- Legal business name, tax identification number or "doing business as" name changes that do not involve a CHOW
- Address changes that do not require a survey of the new location

For these transactions, the contractor shall: (1) notify the supplier via letter, fax, e-mail, or telephone that the change has been made, and (2) switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. The notice to the State/RO shall specify the type of information that is changing.

3. All Other Changes of Information

For all Form CMS-855B change requests not identified in (B)(1) or (B)(2) above, the contractor shall notify the supplier via letter, fax, e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

4. Revalidations, *Form CMS-855B Reactivations, and* Complete CMS-855*B* Applications

In situations where the provider submits a: (1) Form CMS-855B reactivation, (2) Form CMS-855B revalidation, or (3) full Form CMS-855B as part of a change of information (i.e., the supplier has no enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the record to "*Approval Pending Regional Office Review*" only if the application contains new/changed data falling within one of the categories in (B)(1) above. For instance, if a revalidation application reveals a new practice location that was never reported to CMS via the Form CMS-855B, the contractor shall make a recommendation to the State/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward the application to the State with a note explaining that the only matter the State/RO needs to consider is the new location.

If the application contains changed data falling within one of the categories in (B)(2) above, the contractor can switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 days after it has completed processing the transaction.

C. Supplier-Specific, Non-CMS-855 Changes

If the contractor receives a tie-in notice or approval letter for a transaction that concerns information not collected on the Form CMS-855B application, the contractor need not ask the supplier to submit a Form CMS-855B change of information.

D. Involuntary Termination Prompted by State/RO

If the contractor receives a tie-out notice from the RO that involuntarily terminates the supplier's Medicare participation because the supplier no longer meets the conditions of coverage, the contractor need not send a letter to the supplier notifying it that its Medicare participation/enrollment has been terminated. The RO will issue such a letter and afford appeal rights.

E. Other Procedures Related to Tie-In/Tie-Out Notices and Approval Letters

1. Receipt of Tie-In When Form CMS-855B Not Completed

If the contractor receives a tie-in notice or approval letter from the RO but the supplier never completed the necessary Form CMS-855B, the contractor shall have the supplier complete and submit said form. This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency

There may be instances when the RO delegates the task of issuing tie-in/tie-out notices or approval letters to the State agency. The contractor may accept such notices from the State in lieu of those from the RO. However, the contractor should first contact the applicable RO to confirm: (1) that the RO has delegated this function to the State, and (2) the specific transactions (e.g., CHOWs, site additions) for which this function has been delegated.

3. Review for Consistency

When the contractor receives a tie-in notice or approval letter from the RO, it shall review its contents to ensure that the data on the notice/letter matches that on the Form CMS-855B. If there are discrepancies (e.g., different legal business name, address), the contractor shall contact the applicable RO to determine why the data is different.

4. Creation of New Logging and Tracking (L & T) Record Unnecessary

The contractor is not required to create a new L & T record in PECOS when the tie-in notice or approval letter arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. Supplier Inquiries

Once the contractor makes its recommendation for approval to the State/RO, any inquiry the contractor receives from the supplier regarding the status of its request for Medicare participation shall be referred to the State or RO.

6. *Delays in Issuance*

So as not to keep the PECOS record in "*Approval Pending Regional Office Review*" status interminably, if the contractor does not receive notification of approval from the RO after what it deems to be an excessive amount of time, it may contact the RO to see if such approval is forthcoming.

7. Processing Timeframes

With respect to Form CMS-855B transactions for which a post-tie-in notice/approval letter site visit is not required, the contractor shall complete its processing of said notice/letter within 21 calendar days after its receipt of the tie-in/approval notice. For purposes of this requirement, the term "processing" includes all steps taken by the contractor's enrollment and non-enrollment units (e.g. financial area, reimbursement area) to establish the supplier's ability to bill Medicare such as, but not limited to:

a. Entering all relevant data into PECOS.

b. Changing the supplier's PECOS record to the appropriate status (e.g., "approved").

c. Facilitating the supplier's electronic funds transfer and electronic data interchange arrangements.

d. Notifying the supplier (via any mechanism the contractor chooses) that it may begin billing.

The 21-day period begins on the day that the contractor receives the tie-in notice and ends on the day that the contractor notifies the provider that it can commence billing.

Regarding Form CMS-855B transactions that require a post-tie-in notice/approval letter site visit, the contractor shall process the tie-in notice/letter within 45 calendar days of its receipt of the notice/letter. This is to account for the additional time needed for the site visit to be performed.

15.8.1 – Returns

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Reasons for Return

Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the National Supplier Clearinghouse) may immediately return the enrollment application to the provider or supplier only in the instances described below. This policy – again, unless stated otherwise in this chapter or in another CMS directive - applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations):

- The applicant sent its paper Form CMS-855 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).

- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSs).

- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.

- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.

- The application is not needed for the transaction in question. Two common examples include:

  - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

  - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.

The contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a "rejected" application and a "returned" application is that the former is typically based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is effectively considered a non-application.

B. Procedures for Returning the Application

If the contractor returns the application:

- It shall notify the provider via letter (sent by mail or e-mail) that the application is being returned, the reason(s) for the return, and how to reapply.

- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

It shall return all paper documents submitted with the paper or Internet-based PECOS application (e.g., Form CMS-588, Form CMS-460). The contractor shall, however, make and keep a photocopy or scanned version of the paper application (if applicable) and any paper documents (regardless of whether the application was submitted via paper or electronically) prior to returning them.

C. Other Impacts of a Return

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor returns 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 referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Return, Rejection, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 15.8.2 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

***2. Reactivations –** If the contractor returns a reactivation application, the provider's Medicare billing privileges shall remain deactivated.*

***3. Revalidations –** If the contractor returns a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) returns it again, (2) rejects it per section 15.8.2 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.*

15.8.2 –Rejections

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Background

In accordance with 42 CFR § 424.525(a)(1) and (2), the contractor (including the National Supplier Clearinghouse) may reject the provider's application if the provider fails to furnish complete information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. For purposes of this policy, this includes situations in which 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:

(1) The Form CMS-855 or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) certification statement: (a) is unsigned; (b) is undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); or (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form.

(2) The submitted paper application is an outdated version of the Form CMS-855.

(3) The applicant failed to submit all of the forms needed to process a reassignment package within 15 calendar days of receipt.

(4) The Form CMS-855 was completed in pencil.

(5) The wrong application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment).

(6) If a Web-generated application is submitted, it does not appear to have been downloaded from CMS' Web site.

(7) The provider sent in its application or Internet-based PECOS certification statement via fax or e-mail when it was not otherwise permitted to do so.

(8) The provider failed to submit an application fee (if applicable to the situation).

The applications described in (1) through (8) above shall be developed, rather than returned. For instance, if the 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. Timeframe

The 30-day clock identified in 42 CFR § 424.525(a) starts on the date that the contractor mails, faxes, or e-mails the pre-screening 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 pre-screening letter was sent. However, the contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.

C. Incomplete Responses

The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested data, 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 examples:

- The 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 a completed section 3A. However, section 3B remains blank. The contractor need not make a second request for section 3B to be completed. It can reject the application on March 31, or 30 days after its initial request was made.

- The provider submits an outdated version of the Form CMS-855B. On July 1, the contractor requests that the provider resubmit its application using the current version of the Form CMS-855B. On July 15, the provider submits the correct version, but section 4B is blank. The contractor is not required to make a follow-up request regarding section 4B. It can reject the application on July 31.

D. Creation of Logging & Tracking (L & T) Record

If the contractor cannot create an L & T record in PECOS because of missing data and the application is subsequently rejected, the contractor shall document the provider file accordingly. If the contractor is able to create an L & T record for a rejected application, it shall flip the status to "rejected" in PECOS.

E. Other Impacts of a Rejection

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor rejects a change of information or CHOW submission per this section 15.8.2 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) notifying him or her of the rejection. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) 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 referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Rejection, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either rejects it again, returns it per section 15.8.1 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

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

***3. Revalidations –** If the contractor rejects a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) rejects it again, (2) returns it per section 15.8.1 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise –deactivate the provider's billing privileges, assuming the applicable time period has expired.*

F. **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 (either via paper or Internet-based PECOS) and all necessary documentation.

2. **Applicability –** Unless stated otherwise in this chapter or in another CMS directive, this section 15.8.2 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations).

3. **Physicians and Non-Physician Practitioners** – Prior CMS guidance instructed contractors to deny, rather than reject, incomplete applications submitted by physicians and certain non-physician practitioners. This policy no longer applies. Such applications shall be rejected if the physician or practitioner fails 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 mail 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 or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be rejected.

5. **Copy of Application** – If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents 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.

15.8.4 – Denials

(Rev.474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)

A. Denial Reasons

Per 42 CFR §424.530(a), the contractor must deny an enrollment application if any of the situations described below are present, and must provide appeal rights.

When issuing a denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.530(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter 15 as the basis for denial. *Except in the situations outlined in section 15.8.4(B) below, the contractor may issue a denial without prior approval from the Provider Enrollment Operations Group (PEOG).*

If the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the State/Regional Office (RO). The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the provider. The contractor shall copy the State and the RO on said letter.

*D*enial Reason 1 (42 CFR §424.530(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the Medicare enrollment requirements described in this section 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:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it seeks to enroll as. *(See section 15.4.8 of this chapter for examples of suppliers that are not eligible to participate.)*

f. 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 officia*l.*

g. 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 (e.g., marriage counselors.)) 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)).

h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - 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 15.4 et seq. of this chapter.

NOTE: The contractor must identify in its denial letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance wit*h.*

*D*enial Reason 2 (42 CFR §424.530(a)(2)) – Excluded*/Debarred* from Federal Program

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- 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

- 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.

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

The provider, supplier, or any owner of the provider or supplier was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include—

- 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 outlined in section 1128 of the Social Security Act.

While, as discussed in section 15.27.2(D) of this chapter, the contractor shall establish an enrollment bar for providers and suppliers whose billing privileges are revoked, this does not preclude the contractor from denying re-enrollment to a provider or 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.

If the contractor is uncertain as to whether a particular felony falls within the purview of 42 CFR §424.530(a)(3), it should contact its PEOG BFL for assistance.

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

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

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

CMS or its contractor(s) determines, upon on-site review or other reliable evidence, that the provider or supplier is not operational or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is not operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is not operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Denial Reason 6 (42 CFR §424.530(a)(6)) – Existing Overpayment at Time of Application

The current owner (as defined in §424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Denial Reason 7 (42 CFR §424.530(a)(7)) – Medicare Payment Suspension

The current owner (as defined in §424.502), physician or non-physician practitioner has been placed under a Medicare payment suspension as defined in §405.370 through §405.372.

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

An HHA submitting an initial application for enrollment:

- 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

- Fails to satisfy the initial reserve operating funds requirement in 42 CFR §489.28*(a).*

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

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 42 CFR §424.530(a)(1) as a basis for denial when the institutional provider:

- Does not submit a hardship exception request and fails to submit the application fee within the prescribed timeframes, or

- Submits the fee, but it cannot be deposited into a government-owned account.*)*

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

*T*he 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.)

B. Denial Letters

1. General

When a decision to deny is made, the contractor shall send a letter to the provider identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of those shown in section 15.24 et seq. of this chapter. *Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier:*

- *No later than 5 business days after the contractor concludes that the provider or supplier's application should be denied, or*

- *If the denial requires prior Provider Enrollment Operations Group (PEOG) authorization, no later than 5 business days after PEOG notifies the contractor of such authorization.*

No reenrollment bar shall be established for denied applications. Reenrollment bars apply only to revocations.

2. Prior PEOG Approval

Prior to sending the denial letter, the contractor shall obtain approval of both the denial and the denial letter from its PEOG BFL if the denial involves any of the following situations:

- Situation (d), (e), (g) or (h) under Denial Reason *1 above.*

- §424.535(a)(2), (a)(3), or (a)(4).

C. Post-Denial Submission of Enrollment Application

A provider or supplier that is denied enrollment in the Medicare program may not submit a new enrollment application until either of the following has occurred:

- *If the denial was not appealed, the provider or supplier's appeal rights have lapsed, or*

- *If the denial was appealed, the provider or supplier has received notification that the determination was upheld.*

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.

As stated in 42 CFR §424.530(c), if the denial was due to adverse activity (e.g., exclusion, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

E. Other Impacts of a Denial

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor denies a change of information or CHOW submission per this section 15.8.4 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) notifying him or her of the denial. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

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

c. Second Denial, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either denies it again, returns it per section 15.8.1 of this chapter, or rejects it per section 15.8.2 of this chapter, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – *If the contractor denies a reactivation application, the provider's Medicare billing privileges shall remain deactivated.*

3. Revalidations – *If the contractor denies a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - revoke the provider's Medicare billing privileges under 42 CFR § 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall revoke the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) denies it again, (2) returns it per section 15.8.1 of this chapter, or (3) rejects it per section 15.8.2 of this chapter, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – revoke the provider's billing privileges, assuming the applicable time period has expired.*

F. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

G. Final Adverse Actions

See section 15.5.3 of this chapter for information regarding the circumstances in which the contractor shall refer final adverse actions to its PEOG BFL.

15.11 – Electronic Fund Transfers (EFT)

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 before the contractor can effectuate the change. With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data.

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

- All providers (including Federal, State and local governments) enrolling in Medicare must use EFT in order to receive payments. Moreover, any provider not currently on EFT that (1) submits any change to its existing enrollment data or (2) submits a revalidation application must also submit a Form CMS-588 and thereafter receive payments via EFT.

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

B. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

- The information submitted on the Form CMS-588 is complete and accurate.

- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

- The routing number and account number matches what was provided on the Form CMS-588.

- The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or submit a written signature via the paper Form CMS-588)

Once the Form CMS-588 has been processed, the 588 form will be printed and delivered to the contractor's financial area along with the voided check and letter from the bank verifying account information, for proper processing of the EFT information. If this information cannot be verified and the provider fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855.

C. Miscellaneous Policies

1. Banking Institutions - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider's bank of choice does not or will not participate in the provider's proposed EFT arrangement, the provider must select another financial institution.

2. Verification - The contractor shall ensure that all EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.

3. Sent to the Wrong Unit - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 in the file.

4. Comparing Signatures - If the contractor receives an EFT change request, it shall compare the signature thereon with the same official's signature on file to ensure that it is the same person. If the person's signature is not on file, the contractor shall request that he/she complete section 6 of the Form CMS-855 and furnish his/her signature in section 15 or 16. (This shall be treated as part of the EFT change request for purposes of timeliness and reporting.)

5. Bankruptcies and Garnishments – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel.

6. Closure of Bank Account – If a provider has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider on payment withhold until an EFT agreement (and Form CMS-855, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence revocation procedures in accordance with the instructions in this chapter. The basis for revocation would be § 424.535(a) due to the provider's failure to comply with the EFT requirements outlined in § 424.510(e)(1) and (e)(2).

7. Reassignments – If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2)

accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

8. Final Payments – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider's EFT account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855 or Form CMS-588 request identifying where it wants payments to be sent.

9. Chain Organizations - Per CMS Publication 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted. If any of the chain providers have never completed a Form CMS-855 before, they must do so at that time.

15.16.5 – Conversion from Form CMS-855O to Form CMS-855I – PECOS Requirements

Internet-based PECOS permits an individual provider to convert his or her current Form CMS-855O application to a Form CMS-855I enrollment and vice versa. Such providers shall follow the current process for creating a new application. When PECOS detects existing approved enrollments, the provider will be prompted to select from a list of those enrollments that will be used to pre-populate the information for the new application. The provider must confirm that he or she wants to withdraw the existing enrollments before the new application may be submitted.

The enrollments to be withdrawn are displayed in a new section of the ADR in PECOS Administrative Interface (AI). The contractor shall review this information and take the appropriate action to voluntarily withdraw the enrollments listed. The contractor shall begin working the Form CMS-855I enrollment but leave it in "In Review" status while withdrawing the other enrollments. A logging and tracking (L&T) submittal reason of Voluntary Termination shall be used to withdraw the Form CMS-855O enrollment. The effective date of the withdrawn enrollments shall be one day prior to the effective date of the Form CMS-855I enrollment. If it is determined that the Form CMS-855O enrollment requiring withdrawal is outside of the contractor's jurisdiction, the contractor shall notify the other contractor via email using the "Associate Profile Contact List," stating that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and include the email in its files as documentation.

If the provider submits a paper Form CMS-855I application and it is determined that a current Form CMS-855O enrollment exists within the contractor jurisdiction, the contractor shall voluntarily withdraw the Form CMS-855O enrollment. If it is determined that the current Form CMS-855O enrollment is outside of the contractor's jurisdiction, the contractor shall notify the other contractor via email using the "Associate Profile Contact List" that the enrollment needs to be voluntary withdrawn. The second contractor shall take action based on the email and include the email in its files as documentation.

If the provider submits a paper Form CMS-855O to voluntarily withdraw his or her enrollment as well as a paper Form CMS-855I to begin billing Medicare, the contractor shall not contact the provider to confirm the submissions unless the contractor has reason to believe that what was submitted was not the provider's intention. If it is determined that the provider submitted applications to convert his or her existing Form CMS-855O enrollment into a Form CMS-855I enrollment in error (either via paper or Internet-based PECOS), the contractor shall reject the application, thus returning the enrollment record back to its previous state.

15.19.1 – Application Fees

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Background

Pursuant to 42 CFR §424.514 - and with the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR §424.515, must submit with their application:

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

This requirement applies to applications that the contractor receives on or after March 25, 2011.

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

B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year *(1)* in which the application is submitted *(for Internet-based PECOS applications) or (2) of the postmark date (for paper applications).* The fee for March 25, 2011 through December 31, 2011 was $505.00. The fee for January 1, 2013 through December 31, 2013 is $532.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

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

a. A hardship exception request that is subsequently approved;

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

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

(For purposes of (B)(2)(b) above, the term "rejected" includes applications that are returned pursuant to section 15.8.1 of this Chapter.)

In addition, the fee should be refunded if:

- It was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number).

- It was not part of an application submission.

3. Format

The provider or supplier must submit the application fee electronically through Pay.gov, either via credit card, debit card, or check.

Also, with respect to the application fee requirement:

- The fee is based on the Form CMS-855 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

- A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is: (1) Tribally-owned/operated, or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

C. Hardship Exception

1. Background

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

2. Criteria for Determination

The application *fee generally* should not represent a significant burden for an adequately capitalized provider or supplier. Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

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

(a) Considerable bad debt expenses,

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

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

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

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

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL). PEOG has 60 calendar days from the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. PEOG will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 19.1(D) below.

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

D. Receipt

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

a. Determine whether the provider has: (1) paid the application fee via Pay.gov, and/or (2) included a hardship exception request with the application or certification *statement.*

b. If the provider:

i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

During this 30-day period, the contractor *shall determine whether* the fee has been paid via Pay.gov. If the fee is paid within the 30-day period, the contractor may begin processing the application as normal. If the fee is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR §424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

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

ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.

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

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

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

b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied). The contractor shall begin processing the application as normal.

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

In all cases, the contractor shall not begin processing the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved.

E. Year-to-Year Transition

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

During this 30-day period, the contractor shall determine whether the correct fee has been paid via Pay.gov. If it has been, the contractor may begin processing the application as normal. If it is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR §424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof that the correct fee amount (i.e., the Year 2 amount) has been paid, the contractor shall begin processing the application as normal.

F. Appeals of Hardship Determinations

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

1. If the provider is dissatisfied with PEOG's decision to deny a hardship exception request, it may file a written reconsideration request with PEOG within 60 calendar days from receipt of the notice of initial determination (e.g., PEOG's denial letter). The request must be signed by the individual provider or

supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

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

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post-hardship exception request instructions in subsections (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

PEOG has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be:

(a) Conducted by a PEOG staff person who was independent from the initial decision to deny the hardship exception request.

(b) Based on PEOG's review of the original letter and documentation submitted by the provider.

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

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

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

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

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

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

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

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

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

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

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

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

F. Miscellaneous

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non-physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. (This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.) If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application.

3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:

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

    - Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS)

- Requesting a reactivation of the provider's Medicare billing privileges

- Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed below. Physicians, non-physician practitioners, physician groups and non-physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per section 15.19.2.5 of this chapter. Similarly, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

4. Non-Payment of the Fee - If the application is rejected or denied due to non-payment of the fee, the contractor shall:

- Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.

- Indicate in PECOS that a developmental request was made.

- Switch the enrollment record to a "denied" or "rejected" status, as applicable per section 19.1(D).

- Notify the applicant of the rejection or denial in accordance with section 19.1(D).

15.19.2.4 – Reactivations

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Form CMS-855 Reactivations

1. Limited

*Form CMS-855 r*eactivation applications submitted by providers and suppliers in the "limited" level of categorical screening shall be processed in accordance with existing instructions.

2. Moderate

*Form CMS-855 r*eactivation applications submitted by providers and suppliers in the "moderate" level of categorical screening – including existing home health agencies and suppliers of durable medical equipment, prosthetics, orthotics and suppliers (DMEPOS) – shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor's final decision regarding the application.

3. High

*Form CMS-855 r*eactivation applications submitted by providers and suppliers in the "high" level of categorical screening shall be processed in accordance with the screening procedures for this category. A site visit will therefore be necessary prior to the contractor's final decision regarding the application.

B. Reactivation Certification Packages (RCPs)

For RCPs (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter), a site visit is required if the provider is in the moderate or high screening category. A site visit is not required if the provider is in the limited screening category.

15.25.1.2 – Reconsideration Requests

(Rev.474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)

A. Timeframe for Submission

A supplier that wishes to request a reconsideration must file its request in writing with the Medicare contractor *within 60 days from the supplier's receipt of the notice of denial or revocation to be considered timely filed. Per 42 CFR § 498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. A* reconsideration request submitted on the 65th day that falls on a weekend or holiday shall still be considered timely filed. The date on which the contractor receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, the reconsideration HO shall make a finding of good cause before taking any other action on the appeal. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

B. Signatures

The reconsideration request must be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(**N*OTE*:** The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.)

For DMEPOS suppliers, the request must be signed by the authorized official, delegated official, owner or partner.

C. Contractor's Receipt of Reconsideration Request

Upon receipt of a reconsideration request, the HO shall send a letter to the supplier to acknowledge receipt of its request. In his or her acknowledgment letter, the HO shall advise the requesting party that the reconsideration will be conducted and a determination issued within 90 days from the date of the request. The HO shall include a copy of the acknowledgment letter in the reconsideration file.

D. Reconsideration Determination

If a timely request for a reconsideration is made, the reconsideration shall be conducted by a HO or senior staff having expertise in provider enrollment and who was not involved in the (1) initial decision to deny or revoke enrollment, or (2) the CAP determination. The HO must hold an on-the-record reconsideration and issue a determination within 90 days of the date of the appeal request.

Consistent with 42 CFR § 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the HO's decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,

- The findings on which the initial determination was based,

- The evidence considered in making the initial determination, and

- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Although the contractor, like the provider or supplier, may submit new evidence, it may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

E. Issuance of Reconsideration Decision

The HO shall issue a written decision within 90 days of the date of the request. He/she shall: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the supplier. The reconsideration letter shall include:

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;

- A summary of the documentation that the supplier provided;

- A clear explanation of why the HO is upholding or overturning the denial or revocation action in sufficient detail for the supplier to understand the HO's decision and, if applicable, the nature of the supplier's deficiencies;

- If applicable, the regulatory basis to support each reason for the denial or revocation;

- If applicable, an explanation of how the supplier does not meet the enrollment criteria or requirements;

- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the addresses to which the written appeal must be mailed or e-mailed; and

- Information the supplier must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

If the HO overturns the contractor's decision, the contractor shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For initial enrollments, the effective date of Medicare billing privileges is based on the date the supplier came into compliance with all Medicare requirements or the receipt date of the application – subject, of course, to any applicable "backbilling" restrictions. (See section 15.17 of this chapter for more information.) The contractor shall use the receipt date of the reconsideration request as the receipt date entered in the Provider Enrollment, Chain and Ownership System. For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse.

F. Withdrawal of Reconsideration Request

The supplier or the individual who submitted the reconsideration request may withdraw the reconsideration request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with the Medicare contractor. If the contractor receives such a request, it shall

send a letter or e-mail to the supplier acknowledging the receipt of the request and advising that the reconsideration action will be terminated.

G. Reports

The contractor shall maintain a report detailing the number of reconsideration requests it receives, the outcomes (e.g., decision withheld, reversed, or further appeal requested or requests withdrawn), and the reason(s) for whatever decision was made. The contractor is not required to submit this information to CMS but it must be provided upon request.

15.25.2.2 – Reconsideration Requests

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Timeframe for Submission

A provider that wishes to request a reconsideration must submit its request, in writing, to the Provider Enrollment Operations Group (PEOG) within 60 days *from the supplier's receipt of the notice of denial or revocation to be considered timely filed. Per 42 CFR § 498.22(b)(3), the date of receipt is presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later.* The mailing address is:

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

PEOG will extend the filing period an additional 5 days to allow for mail time. A reconsideration request submitted on the 65th day that falls on a weekend or holiday will still be considered timely filed. The date on which PEOG receives the request is considered to be the date of filing.

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. However, if a request for reconsideration is filed late, PEOG will make a finding of good cause before taking any other action on the appeal. The time limit may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

B. Signatures

A reconsideration request must be signed by an authorized official, delegated official, or legal representative of the provider. The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

C. Receipt of Reconsideration Request

Upon receipt of a reconsideration request, PEOG will send a letter to the provider to acknowledge receipt of the request. In its acknowledgment letter, PEOG will advise the provider that the reconsideration will be

conducted and a determination issued within 90 days from the date of the request. PEOG will include a copy of the acknowledgment letter in the reconsideration file.

If the contractor inadvertently receives a reconsideration request from a certified provider or certified supplier, it shall immediately forward it to PEOG at this address or, if possible, to the following PEOG mailbox: providerenrollmentappeals@cms.hhs.gov.

D. Reconsideration Determination

As already stated, if a timely request for a reconsideration is made, PEOG will consider the request and issue a determination within 90 days of the request.

Consistent with 42 CFR § 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the HO's decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under § 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Although the contractor, like the provider or supplier, may submit new evidence, it may not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination during the reconsideration process.

E. Issuance of Reconsideration Decision

PEOG will issue a written decision within 90 days of the date of the request. It will: (1) forward the decision to the Medicare contractor via e-mail, fax, or mail, and (2) mail the decision to the provider or the individual who signed the reconsideration request. The reconsideration letter will include:

- The re-stated facts and findings, including the regulatory basis for the action as determined by the contractor in its initial determination;
- A summary of the documentation that the provider furnished;
- A clear explanation of why PEOG is upholding or overturning the denial or revocation action in sufficient detail for the provider to understand PEOG's decision and, if applicable, the nature of the provider's deficiencies;
- If applicable, the regulatory basis to support each reason for the denial or revocation;
- If applicable, an explanation of how the provider does not meet the enrollment criteria or requirements;
- Further appeal rights, procedures for requesting an administrative law judge (ALJ) hearing, and the address to which the written appeal must be mailed or e-mailed; and
- Information that the provider must include with its appeal (name/legal business name; supplier number (if applicable); tax identification number/employer identification number (TIN/EIN); and a copy of the reconsideration decision).

If PEOG approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and issue or restore billing privileges (as applicable), and (2) notify the provider thereof via letter. If applicable, PEOG will also notify the contractor of the effective date.

F. Withdrawal of Reconsideration Request

The provider or the individual who signed the reconsideration request may withdraw its request at any time prior to the mailing of the reconsideration decision. The withdrawal request must be in writing, signed, and filed with PEOG at the address in (A) above.

15.27.1 – Deactivations and Reactivations

(Rev.474, Issued: 07-05-13, Effective:10-08-13, Implementation: 10-08-13)

15.27.1.1 – Deactivations

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor may - with prior approval from its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) - deactivate a provider or supplier's Medicare billing privileges when:

- *Per § 424.540(a)(1), a provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;*

- *Per § 424.540(a)(2), a provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or*

- *Per § 424.540(a)(2), a provider or supplier fails to report a change in ownership or control within 30 calendar days.*

The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

Should the contractor encounter one of the three deactivation situations described above, it shall contact its PEOG BFL (via any means) and request approval of the deactivation. PEOG will notify the contractor of its decision.

B. Effective Dates

The effective dates of a deactivation are as follows:

1. Non-Billing – The effective date is the date of the expiration of the applicable 12-month period.

2. Failure to Report Changed Information – The effective date is the date of the expiration of the application 30-day or 90-day reporting period. (See subsection A above.)

3. The "36-Month Rule" for HHAs – The Provider Enrollment Operations Group (PEOG) will determine the effective date during its review of the case.

C. Appeals Rights

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is made.

D. Miscellaneous Policies

1. In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor shall only deactivate the non-billing PTAN(s). If a provider with multiple PTANs is to be deactivated for any reason other than (1) non-billing or (2) failing to respond to a revalidation request, the contractor shall contact its PEOG BFL for guidance as to the specific PTANs that should be deactivated.

2. A "no payment" bill with a condition code 21 (billing for denial notice) is considered a Medicare claim for purposes of 42 CFR § 424.540. A "demand bill" (as described in Pub. 100-08, chapter 3, section 5.4 (Exhibit 1)) is considered a Medicare claim for purposes of 42 CFR § 424.540. Thus, for instance, if the provider only submitted "no payment" or "demand" bills over a 12-month period and furnished no claims for payment, the provider still submitted Medicare claims under § 424.540. Deactivation for non-billing would therefore be inappropriate.

3. Consistent with prior CMS direction, Medicare claims administration contractors and the EDCs shall not run the following deactivation jobs:

- *Multi-Carrier System - Job names MV50, MV51, MV52 and MV53*
- *Fiscal Intermediary Shared System – Job name FSSJ9220*

CMS, of course, retains the discretion to deactivate a provider or supplier's Medicare billing privileges if any of the situations described in 42 CFR § 424.540(a) are implicated.

4. 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 Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for review and approval.

15.27.1.2 – Reactivations

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

Sections 15.27.1.2.1 through 15.27.2.2 below discuss the requirements for reactivating a provider or supplier's billing privileges.

If the contractor approves a provider or supplier's reactivation application or reactivation certification package (RCP), the reactivation effective date shall be the provider or supplier's date of deactivation. (If the contractor determines that the provider or supplier fell out of – yet came back into- compliance with enrollment requirements during the period of deactivation, it shall contact its PEOG BFL for guidance as to how the situation should be handled.)

Also, with the exception of HHAs, reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new 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 its billing privileges can be reactivated. (See section 15.26.3 of this chapter for more information.)

15.27.1.2.1 – Reactivations - Deactivation for Reasons Other Than Non-Submission of a Claim

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Background

To reactivate its billing privileges, a provider or supplier deactivated for failing to timely notify the contractor of a change of information (see section 15.27.1.1(A) above) must either:

1. Submit a complete Medicare enrollment application, or

2. Recertify that its enrollment information currently on file with Medicare is correct.

B. Certification Option

1. General Requirements

To utilize option (A)(2) above, the provider or supplier must submit to the contractor (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, and (c) a letter certifying as to the data's accuracy. The letter must:

(i) Be on the provider or supplier's letterhead.

(ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.

(iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.

(iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 certification statement).

(v) Contain the following language:

For Individual Practitioners

"I, _____, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agrees to abide by them."

A separate Form CMS-855 certification statement and letter must be submitted with each PECOS enrollment record (and the PTANs in that record) the provider or supplier seeks to have reactivated. To illustrate, suppose a supplier has three separate enrollments it wants to reactivate. Each enrollment has its own PECOS enrollment record. Two of the records have one PTAN; the third record contains two PTANs. The supplier must submit three separate PECOS Web printouts, three separate certification statements, and three separate letters. (The letter pertaining to the third enrollment record must list both PTANs.) The certification statement and letter should be attached to the PECOS Web printout to which it pertains – meaning, per our example, that there would be three separate "reactivation certification packages" (RCPs). All RCPs must be submitted via mail. They cannot be faxed or e-mailed.

The provider or supplier cannot utilize the certification option and must submit a complete Form CMS-855 application if:

- *There is any information in the provider or supplier's PECOS Web enrollment record that is not correct.*

- *The provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS).*

- *The provider or supplier cannot otherwise produce a valid RCP.*

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- *Shall ensure that it is complete and contains all of the elements identified in (B)(1) above. If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.*

- *Shall review all names listed in the provider's enrollment record against the Medicare Exclusion Database (MED) and General Services Administration (GSA) Access Management System.*

- *Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).*

- *Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.*

- *Reserves the right to request a full Form CMS-855 application if the contractor has reason to believe that any data in the provider's enrollment record is inaccurate or outdated. However, it shall obtain the approval of its Provider Operations Enrollment Group Business Function Lead (PEOG BFL) before making this request.*

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.1(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider is operational per the site visit, and (5) for HHAs, has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (As stated earlier, though, rejection is appropriate if the provider does not adequately respond to the provider's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.

15.27.1.2.2 – Reactivations - Deactivation for Non-Submission of a Claim
(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

To reactivate its billing privileges, a provider or supplier deactivated for non-billing must recertify that its enrollment information currently on file with Medicare is correct. This section 15.27.1.2.2 discusses this requirement.

A. All of Provider's Data in Enrollment Record Is Correct

1. General Requirements

If all of the data in the provider or supplier's enrollment record is correct, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) a hard copy Form CMS-855 certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (c) the claim data described in section 15.27.1.2.3(B) of this chapter, and (d) a letter certifying as to the data's accuracy. The letter must:

(i) Be on the provider or supplier's letterhead.

(ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), National Provider Identifier, and the Provider Transaction Access Number(s) (PTAN) in the provider or supplier's enrollment record to be reactivated.

(iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.

(iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 certification statement).

(v) Contain the following language:

For Individual Practitioners

> *"I, _____, certify that all of the information contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."*

For Authorized/Delegated Officials

> *"I, _____, in my capacity as an authorized or delegated official of (Provider/Supplier), certify on behalf of (Provider/Supplier) that all of the information contained in (Provider/Supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (Provider/Supplier) is bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agrees to abide by them."*

As explained in section 15.27.1.2.2(A), a separate Form CMS-855 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All

such "reactivation certification packages" (RCPs) must be submitted via mail. They cannot be faxed or e-mailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- *Shall ensure that it is complete and contains all of the elements identified in (A)(1) above.*

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (4) the certification statement or letter is undated; (5) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- *Shall review all names listed in the provider's enrollment against the Medicare Exclusion Database (MED) and General Services Administration (GSA) Access Management System.*

- *Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).*

- *Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.*

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(A), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, and (5) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.

B. Some of Provider's Data in Enrollment Record Is Incorrect

1. General Requirements

If any data in the provider or supplier's enrollment record is incorrect, the provider must submit to the contractor: (a) a hard copy print-out of its PECOS Web enrollment data, (b) applicable hard-copy page(s) of the Form CMS-855 containing the corrected information (e.g., new section 8 reporting a change to the billing company address), (c) a certification statement signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official, (d) the claim data described in section 15.27.1.2.3(B) of this chapter, and (e) a letter certifying as to the rest of the enrollment data's accuracy. The letter must:

(i) Be on the provider or supplier's letterhead.

(ii) List the provider or supplier's birth name or legal business name, doing business as name (if applicable), NPI, and PTAN(s).

(iii) Must state that the provider is seeking to reactivate his/her/its billing privileges.

(iv) Be signed and dated by the enrolled individual practitioner or, as applicable, the provider or supplier's authorized or delegated official (who must be the same person who signed the Form CMS-855 certification statement).

(v) Contain the following language:

For Individual Practitioners

"I, _____, certify that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted Form CMS-855 pages) - all of the information currently contained in Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, I am bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agree to abide by them."

For Authorized/Delegated Officials

"I, _____, in my capacity as an authorized or delegated official of (provider/supplier), certify on behalf of (provider/supplier) that - with the exception of (list the data elements that are currently incorrect and are being updated via the submitted Form CMS-855 pages) - all of the information contained in (provider/supplier's) Medicare enrollment record (the record's PAC ID number) is truthful and accurate. I understand that by this statement and by my signature below, (provider/supplier) is bound by all of the terms and conditions of the attached, signed Form CMS-855 certification statement and agrees to abide by them."

As explained in section 15.27.1.2.2(B), a separate Form CMS-855 certification statement and letter must be submitted with each PECOS enrollment record the provider or supplier seeks to have reactivated. The certification statement and letter should be attached to the PECOS Web printout to which it applies. All RCPs must be submitted via mail. They cannot be faxed or e-mailed.

2. Contractor Processing

Upon receipt of an RCP, the contractor:

- *Shall ensure that it is complete and contains all of the elements identified in (B)(1) above.*

If the RCP is in any way deficient or incomplete, the contractor shall develop for the missing/incomplete information or documentation consistent with existing procedures (e.g., requesting the submission of a revised letter). Examples of a deficient RCP include, but are not limited to, the following: (1) the package is missing the printout, certification statement, or letter; (2) the letter does not contain the required language or contains verbiage that offsets the required language; (3) the letter does not identify the information in the enrollment record that is incorrect; (4) the certification statement or letter is signed by an individual who is not on record as an authorized or delegated official; (5) the certification statement or letter is undated; (6) the letter refers to the incorrect PAC ID number. The contractor may reject the RCP if the provider fails to furnish the requested material within 30 days of the request.

- *Shall review all names listed in the provider's enrollment against the MED and GSA List.*

- *Shall ensure that the provider is still appropriately licensed and/or certified (e.g., the contractor can check State Web sites).*

- *Consistent with section 15.19.2.4 of this chapter, shall perform a site visit if the provider is in the moderate or high screening category.*

- *Process the changed information in accordance with the instructions in this chapter. The entire RCP transaction (including the changed data) shall, however, be processed as a revalidation.*

The contractor need not prescreen the RCP.

If the contractor determines that (1) the RCP complies with the requirements of this section 15.27.1.2.2(B), (2) remains appropriately licensed and/or certified, (3) none of the names in the provider or supplier's enrollment record are excluded or debarred, (4) the provider (if in the moderate or high screening category) is operational per the site visit, (5) all of the changed information can be processed to approval, and (6) for HHAs, the provider has undergone a new State survey or accreditation, the contractor may reactivate the provider's Medicare billing privileges in accordance with existing procedures. If the contractor determines that any of these criteria are not met, it shall deny the reactivation application in accordance with existing procedures. (Rejection is appropriate, however, if the provider does not adequately respond to the contractor's developmental request.) If the contractor believes that a denial ground other than the aforementioned exists, it shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.

C. PECOS Web Printout

If the provider or supplier cannot produce a printout of the applicable PECOS Web enrollment record (e.g., provider has no enrollment record in PECOS) or cannot otherwise submit a valid RCP, it must submit a complete Form CMS-855 application in order to reactivate its Medicare billing privileges.

15.27.1.2.3 – Reactivations – Miscellaneous Policies

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Full Enrollment Applications

1. For providers that were deactivated for non-billing, the provider may submit a complete Form CMS-855 enrollment application in lieu of an RCP. The application may be submitted via paper or PECOS Web.

2. For Form CMS-855 reactivation applications, the timeliness requirements in sections 15.6.1 et seq., pertaining to initial enrollment applications apply. The contractor shall – unless a CMS instruction directs otherwise - validate all of the information on the application just as it would with an initial application.

3. Unless stated or indicated otherwise:

- *The term "Form CMS-855 revalidations" as used in this chapter 15 only includes Form CMS-855 revalidation applications. It does not include RCPs.*

- *The term "revalidation" as used in this chapter 15 includes Form CMS-855 revalidation applications and RCPs.*

B. Claims

For RCP submissions, the provider must also furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. Alternatively, the provider may include in its RCP letter the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.

C. Development

If the initial RCP is incomplete or inadequate and the contractor initiates development procedures, the following principles apply:

- *The provider may submit the requested documentation to the contractor via fax.*

- *If there are deficiencies in the RCP letter, the provider must submit (1) a new letter, and (2) a newly-signed and dated certification statement. The provider cannot mark-up the previous letter and resubmit it.*

15.27.2 – Revocations

(Rev.474, Issued: 07-05-13, Effective: 10-08-13, Implementation: 10-08-13)

A. Revocation Reasons

(Except in the situations outlined in section 15.27.2(B) below, the contractor may issue a revocation without prior approval from the Provider Enrollment Operations Group (PEOG).)

When issuing a revocation, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR §424.535(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter as the basis for revocation.

Revocation Reason 1 (42 CFR §424.535(a)(1)) – Not in Compliance with Medicare Requirements

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section 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.

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

Other situations in which the contractor shall use §424.535(a)(1) as a revocation reason include, but are not limited to, the following:

a. The provider or supplier does not have a physical business address or mobile unit where services can be rendered.

b. The provider or supplier does not have a place where patient records are stored to determine the amounts due such provider or other person.

c. The provider or supplier is not appropriately licensed.

d. The provider or supplier is not authorized by the Federal/State/local government to perform the services that it intends to render.

e. The provider or supplier does not meet CMS regulatory requirements for the specialty that it is enrolled as.

f. 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.

g. The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or 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. (**NOTE**: This revocation reason should not be used in these cases if CMS has explicitly instructed the contractor to use deactivation reason §424.540(a)(3) in lieu thereof.)

h. The provider or supplier does not otherwise meet general enrollment requirements.

With respect to (e) above – and, as applicable, (c) and (d) - 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 or supplier type. For a listing of some of these statutes and regulations, refer to section 15.4 et seq. of this chapter.

NOTE: The contractor must identify in its revocation letter the exact provision within said statute(s)/regulation(s) that the provider/supplier is not in compliance wit*h.*

*R*evocation Reason 2 (42 CFR §424.535(a)(2)) – Excluded*/Debarred* from Federal Program

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) 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.

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

If an excluded party is found, the contractor shall notify its PEOG Business Function Lead (BFL) immediately. PEOG will notify the Government Task Leader (GTL) for the appropriate Zone Program Integrity Contractor. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigatio*n.*

*R*evocation Reason 3 (42 CFR §424.535(a)(3)) – *Felony Conviction*

The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.

(i) Offenses include—

(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 that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) 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.

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

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

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.)

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

The CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Revocation Reason 6 (§424.535(a)(6)) - Hardship Exception Denial *and* Fee Not Paid

(i) (A) 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

(B) 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.

(ii) (A) Either of the following occurs:

(1) CMS is not able to deposit the full application amount into a government-owned account; or

(2) The funds are not able to be credited to the United States Treasury;

(B) 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

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

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

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.

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

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.

See sections 15.27.3 through 15.27.3.2 of this chapter for instructions regarding the use of this revocation reason.

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

The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii) or (iii), which pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.

NOTE: With respect to Revocation Reason 9:

- This revocation reason only applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.

- If the individual or organization reports a change in practice location more than 30 days after the effective date of the change, the contractor shall not revoke the supplier's billing privileges 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 individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the contractor may revoke the supplier's billing privileges.

Revocation Reason 10 (42 CFR §424.535(a)(10)) – Non-Compliance with Documentation Requirements

The provider or supplier did not comply with the documentation requirements specified in 42 §424.516(f).

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

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

Revocation Reason 12 (42 CFR §424.535(a)(12)) – Medicaid *Billing* Privileges Revoked

The provider or supplier's Medicaid billing privileges are terminated or revoked by a State Medicaid Agency.

(**NOTE:** Medicare may not terminate a provider or supplier's Medicare billing privileges unless and until the provider or supplier has exhausted all applicable Medicaid appeal rights).

See subsection F below for information on a revocation's effect on the provider's other Medicare enrollments.

B. Prior PEOG Approval

Absent a CMS instruction or directive to the contrary, the revocation letter shall be sent to the provider or supplier:

- *No later than 5 business days after the contractor concludes that the provider or supplier's billing privileges should be revoked, or*

- *If the revocation requires prior PEOG authorization, no later than 7 calendar days after PEOG notifies the contractor of such authorization.*

Prior to sending a revocation letter, the contractor shall obtain approval of both the revocation and the revocation letter from its PEOG BFL in the following situations:

- *Any revocation, regardless of the reason, involving (1) a provider or supplier that completes a Form-855A application, (2) an ambulatory surgical center, or (3) a portable x-ray supplier.*

- *A revocation involving a non-certified provider or non-certified supplier that is based on:*

  - *Situation (b), (c), (d), (e), (f), or (h) under Revocation Reason 1 above, or*

  - *§ 424.535(a)(2), (a)(3), (a)(4), (a)(7), (a)(8), (a)(9), (a)(10) and (a)(12).*

During this review, CMS will also determine (1) the extent to which the revoked provider or supplier's other locations are affected by the revocation, and (2) the geographic application of the reenrollment bar. (See subsection F below.)

C. Effective Date of Revocations

Per 42 CFR §405.874(b)(2), a revocation is effective 30 days after CMS or its contractor (including the National Supplier Clearinghouse (NSC)) mails the notice of its determination to the provider or supplier. However, per 42 CFR §424.535(g), a revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction as described in 42 CFR §424.535(a)(3), (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that CMS or the contractor determined that the provider or supplier is no longer operational.

NOTE: *In accordance with 42 CFR §424.565, if a physician, non-physician practitioner, physician organization or non-physician practitioner organization fails to comply with the reporting requirements specified in 42 CFR §424.516(d)(1)(ii), the contractor may assess an overpayment back to the date of the final adverse action, though said date shall be no earlier than January 1, 2009. Moreover, no later than 10 calendar days after the contractor assesses the overpayment, the contractor shall notify its PEOG liaison of the amount assessed.*

As stated in 42 CFR §424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services and/or supplies, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- *Need not solicit or ask for such proof in its revocation letter. It is up to the provider/supplier to furnish this data on its own volition.*

- *Has the ultimate discretion to determine whether sufficient "proof" exists.*

D. Payment

Per 42 CFR §405.874(b)(3), Medicare does not pay and a CMS contractor rejects claims for items or services submitted with a service date on or after the effective date of a provider's or supplier's revocation.

E. Re-enrollment Bar

As stated in 42 CFR §424.535(c), after a provider, supplier, delegated official, or authorized official has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. Per §424.535(c), however, the reenrollment bar does not apply if the revocation (1) is based on §424.535(a)(1), and (2) stems from a provider or supplier's failure to respond timely to a revalidation request or other request for information. If both of these conditions are met, no reenrollment bar shall be applied.

Unless stated otherwise in this section, the re-enrollment bar is a minimum of 1 year but not greater than 3 years, depending on the severity of the basis for revocation. The contractor shall establish the re-enrollment bar in accordance with the following:

1 year (AR 73) – License revocation/suspension that a deactivated provider (i.e., is enrolled, but is not actively billing) failed to timely report to CMS.

2 years (AR 74) – The provider is no longer operational.

3 years (AR 81) – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information.

For all other revocation reasons, the contractor shall contact its PEOG liaison. PEOG will establish the appropriate enrollment bar for that particular case.

The contractor shall update the Provider Enrollment, Chain and Ownership System (PECOS) to reflect that the individual is prohibited from participating in Medicare for the applicable 1, 2, or 3-year period.

***NOTE:** Also, reenrollment bars apply only to revocations. The contractor shall not impose a reenrollment bar following a denial of an application.*

F. Scope of Revocation and Re-enrollment Bar

The chart below outlines the extent to which (1) a particular revocation generally applies to the provider's other locations and (2) the re-enrollment bar applies.

Revocation Reason	***Scope of Revocation***	***Scope of Bar***
§424.535(a)(1)	*For situation (a) in Revocation Reason 1, applies to the practice location in question, unless CMS determines otherwise.* *For situations (b), (c), (d), (e), (f) and (h) in Revocation Reason 1 above, CMS will determine.*	*For situation (a) in Revocation Reason 1- and unless CMS determines otherwise - applies to (1) the practice location in question, and (2) any effort to re-establish that location (i) at a different address and/or (ii) under a different business or legal identity, structure, or tax identification number (TIN).*

	For situation (g) in Revocation Reason 1, applies to all practice locations under the provider's PECOS or legacy enrollment record, unless CMS determines otherwise.	*For situations (b), (c), (d), (e), (f) and (h) in Revocation Reason 1, CMS will determine.* *For situation (g) in Revocation Reason 1- and unless CMS determines otherwise -applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN.*
§424.535(a)(2)	*CMS (in consultation, as needed, with the appropriate law enforcement agencies) will determine*	*CMS (in consultation, as needed, with appropriate law enforcement agencies) will determine*
§424.535(a)(3)	*CMS will determine*	*CMS will determine*
§424.535(a)(4)	*CMS will determine*	*CMS will determine*
§424.535(a)(5)	*Applies to the practice location in question, unless CMS determines otherwise.* ***NOTE****: The specific location should be end-dated if the PECOS record contains other locations that are not being revoked. For instance, if a group practice has three locations – X, Y and Z - and Location X is determined to be non-operational, X should be end-dated; the entire PECOS record should not be placed in a "Revoked" status if Locations Y and Z are not being revoked.*	*Unless CMS determines otherwise, applies to (1) the practice location in question, and (2) any effort to re-establish that location (i) at a different address and/or (ii) under a different business or legal identity, structure, or tax identification number (TIN).*
§ 424.535(a)(6)	*Applies to all practice locations under the provider's PECOS or legacy enrollment record, unless CMS determines otherwise*	*Unless CMS determines otherwise, -applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN.*

§424.535(a)(7)	*CMS will determine*	*CMS will determine*
§424.535(a)(8)	*CMS will determine*	*CMS will determine*
§424.535(a)(9)	*CMS will determine*	*CMS will determine*
§424.535(a)(10)	*CMS will determine*	*CMS will determine*
§424.535(a)(11)	*Applies to all practice locations and branches under the revoked HHA's provider agreement, unless CMS determines otherwise.*	*Unless CMS determines otherwise, applies to (1) all practice locations and branches under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations or branches (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN.*
§424.535(a)(12)	*CMS will determine*	*CMS will determine*

Thus, for situations (a) and (g) in Revocation Reason 1 and for revocations under § 424.535(a)(5), (a)(6) and (a)(11), the contractor shall apply the revocation and the re-enrollment bar in accordance with this chart. To illustrate, suppose Physician Group X, Inc. enrolled in Medicare in 2009. It has 3 practice locations. One of the locations has been determined to be non-operational and will be revoked. The contractor shall end-date this location but shall not end-date the other two.

In general, and unless stated otherwise above, any re-enrollment bar at a minimum applies to (1) all practice locations under the provider's PECOS or legacy enrollment record, (2) any effort to re-establish any of these locations (i) at a different address, and/or (ii) under a different business or legal identity, structure, or TIN. If the contractor receives an application and is unsure as to whether a revoked provider is attempting to re-establish a revoked location, it shall contact its PEOG BFL for guidance. Instances where the provider might be attempting to do so include - but are by no means limited to – the following:

- *John Smith was the sole owner of Group Practice X, a sole proprietorship. Six months after X was revoked under § 424.535(a)(9), the contractor receives an initial application from Group Practice Medicine, LLC, of which John Smith is the sole owner/member.*

- *Jack Jones and Stan Smith were 50 percent owners of World Home Health Agency, a partnership. One year after World Home Health was revoked under § 424.535(a)(7), the contractor receives an initial application from XYZ Home Health, a corporation owned by Jack Jones and his wife, Jane Jones.*

- *John Smith was the sole owner of XYZ Medical Supplies, Inc. XYZ's lone location was at 1 Jones Street. XYZ's billing privileges were revoked after it was determined that the site was non-operational. Nine months later, the contractor receives an initial application from Johnson Supplies, LLC. The entity has two locations in the same city in which 1 Jones Street is located, and John Smith is listed as a 75 percent owner.*

G. Submission of Claims for Services Furnished Before Revocation

Per 42 CFR §424.535(g), any physician, physician assistants, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist,

registered dietitian or nutrition professional, organization (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

H. Final Adverse Actions

If the contractor learns via any means (e.g., submission of a Form CMS-855, referral from Zone Program Integrity Contractor or law enforcement, notice from another contractor) that an enrolled provider or supplier has had a final adverse action imposed against it, the contractor shall refer the matter to its PEOG BFL for guidance.

I. Notification to Other Contractors

If the contractor revokes a provider or supplier's Medicare billing privileges, the contractor shall determine, via a search of PECOS, whether the provider/supplier is enrolled with any other Medicare contractors. If the contractor determines that the revoked provider/supplier is indeed enrolled with another contractor(s), the revoking contractor shall notify these other contractors of the revocation. The notification shall be done via e-mail and shall contain a short description of the reason for the revocation.

Upon receipt of this notification from the revoking contractor, the receiving contractor shall determine whether the provider or supplier's billing privileges should be revoked in its jurisdiction as well. This may require that the contractor contact its PEOG BFL for guidance per the instructions in this chapter.

J. Provider Enrollment Appeals Process

For more information regarding the provider enrollment appeals process, see section 15.25 of this chapter.

K. Summary

If the contractor determines that a provider's billing privileges should be revoked, it shall undertake the activities described in this section, which include, but are not limited to:

- *Revoking the provider's billing privileges back to the appropriate date;*
- *Establishment of the applicable reenrollment bar;*
- *Updating PECOS to show the length of the reenrollment bar;*
- *Assessment of an overpayment, as applicable;*
- *Providing PEOG with the amount of the assessed overpayment within 10 days of the overpayment assessment; and*
- *Affording appeal rights.*

L. Reporting Revocations/Terminations to the State Medicaid Agencies and Children's Health Program (CHIP)

Section 6401(b)(2) of the Patient Protection and Affordable Health Care Act (i.e., the Affordable Care Act), enacted on March 23, 2010, requires that the Administrator of CMS establish a process for making available to each State Medicaid Plan or Child Health Plan the name, National Provider Identifier, and other identifying information for any provider of medical or other items or services or supplier who have their Medicare billing privileges revoked or denied.

To accomplish this task, the CMS will provide a monthly revoked and denied provider list to all contractors via the Share Point Ensemble site. Contractors shall access this list on the 5th day of each month through the Share Point Ensemble site. Contractors shall review the monthly revoked and denied provider list for the

names of Medicare providers revoked and denied in PECOS. Contractors shall document any appeals actions a provider/supplier may have submitted subsequent to the provider or supplier's revocation or denial.

Contractors shall be required to update the last three columns on the tab named "Filtered Revocations" of the spreadsheet for every provider/supplier revocation or denial action taken. Contractors shall not make any other modifications to the format of this form or its contents. The following terms are the only authorized entries to be made on the report:

Appeal Submitted:
Yes - (definition: an appeal has been received. This includes either a CAP or Reconsideration request or notification of an ALJ or DAB action.)
No - (definition: no appeal of any type has been submitted)

Appeal Type:
CAP
Reconsideration
ALJ
DAB

Appeal Status:
Under Review
Revocation Upheld
Revocation Overturned
Denial Upheld
Denial Overturned
CAP accepted
CAP denied
Reconsideration Accepted
Reconsideration Denied

If a contractor is reporting that no appeal has been submitted, the appeal type and status columns will be noted as N/A.

If an appeal action has been submitted to PEOG for certified providers or suppliers, contractors shall access the PEOG appeal's log via the Share Point Ensemble site to determine the appeal status to include on the spreadsheet.

Contractors shall submit their completed reports by the 20th of each month to its designated PEOG BFL.